Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ STEVEN WADYKA JOHN 2012 9:15P January Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death None Keswick Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 X M 2 🗆 F 79 0*471277-P*1932 Director Connecticut 047-24-0188 Usual Residence of Decedent f show death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 3a or 28a-f sh t be notified a XX Yes 2 No Baltimore Maryland None 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or items 23a Funeral 21218 USA 3401 Greenway #301 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc 1 Never Married 2 X Married filed within 72 hours after δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Divorced 4 Divorced Specify: White Completed permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical once. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Research Analyst Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Phyllis Malachowski Steven Wadyka 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3401 Greenway #301 Baltimore, Maryland 21218 Barbara Ann Wadyka Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State GreenMount Crematory 01/25/2012 Burial XXX Cremation 3 Removal from State
Donation 5 Other (Specify) Baltimore, Maryland Signature of Funeral Se 22. Name and Address of FMitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complicate shock, or heart failure. List only one of ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final hysician/ 2 mordors disease or condition NOUNIN Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine o the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death signed by the a 2 No Yes g 🗌 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 🗂 Unknown 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 ☐ Yes 2 ☐ No To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 🖸 No ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: ✓ Natural 5 Pending injury 2 🗌 No Accident Investigation 6 Could not be within 24 hours after deat To the Funeral Director: Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On ti)e basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nyrse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and t 29d. Date signed (Month, Day, Year) Jonuary 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EUTAW ST SUITE 301 BATIMORE MO 2120 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Deatl Physician/ NNETH Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Nursina MONTGOMETY Ensington Kensing TON 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral Director** 1 M 2 🗆 F Yrs KENTUCKY show 10c. City, Town or Location notified at 10d. Inside City Limits Director 28a-f mi MONTGOMER 1 ¥Yes 2 ☐ No KENSINGTON 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ms 23a or must be n Funeral 20899 nitect oma 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, er than "natural", or iter the Medical Examiner d Forces Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2 No If Yes, Give Year or Dates. 1963-67 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: 3 - Widowed 4 - Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Bethleham and Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be f. Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev 2 illiams State, Zip Code) 207 19b. Mailing Address (Street and Number -Marlboro, MD Adrian alonel Beall t+1brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 1

■ Burial 2

□ Cremation 3

□ Removal from State 4 Donation 5 Other (Specify) Signature of Funeral For ice Licelises Part 1. Inter the disease, or complications that cal shock, or heart failure. List only one cause on each sed the death. Do not enter the mode of dying, such as cardiac or Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CORONARY disease or condition resulting in death) dedical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and I-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician a Physician/Medical Box 68760 attending ph d for use as tí IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 📆 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 N 2 No certificate 1 Yes Division of Vital completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 1 No Hospital Other: 1 Yes 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 ANatural 5 Pending 24 hours after death. Funeral Director: A 1 Yes 2 No M Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the Vithin 2 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 1/23/12

DHMH 17 Rev 06-2011

State Registrar mc(

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

000 57124

omas

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ OCA M 2012 Jan Margaret Elizabeth Wilson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/AB<u>altimore</u> Good Samaritan Hospital 8. Date of Birth (Month, Day, Year) May 9, 1951 9. Birthplace (State or Foreign VA If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number **Funeral** Min. Months Hours May 60 Director 226-78-8081 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Xyes 2 No Baltimore N/AMaryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21239 USA 1664 Winford Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Force Black, White, etc. 1 Never Married 2 Married 2 X No ρ "natural", or Yes and 2 should be filed within 72 hours after 1 ☐ Yes 2 No Specify. Specify: Black If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced other than "natu 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Office Worker Clerical Worker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, and Mental F ျ Sallie Elizabeth Johnson Walter Columbus Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 1664 Winford Road Baltimore, MD 21239 <u>Pearl W. Watson/Sister</u> timore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 1-21-2012 4 Donation 5 Other (Specify) Oaklawn Cemetery Baltimore, MD 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service Licensee 4210 Belair Road Baltimore,MD 21206 ano 23d Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) as a consequence of) Examiner Sequentially list conditions, if any leading to immediate Due to or as a consequence of trany leading to immedicause. Enter Underlying Exami the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Month Year 5 Other (specify) Pregnant at time of death Yes 2 / the a Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 2 No Completed peen: 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy perform death? 1 ☐ Yes 2 ☐ No certificate Was case refer 26. Place of Death (Check only one) director, Be examiner? Hospital Other: 2 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28c. Injury at 28d. Describe how injury occurred After 1 Natural work? 5 Pending within 24 hours and common to the Funeral Director: Af 2 🗌 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) ed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day,

JAN 2 4 2012

DHMH 17 Rev 7/2009

12-00105	Please Type of Print in Black indelible link. Ensure All Copies Are Leg	ainie.		
Oliver Thomas Woodson	State of Maryland / Department of Health and Mental Hygiene		201	2
1- For State	Certificate of Death	eg. No.	201	bee '

er Thomas V		dson	State of Mar	yland / Depa	rtment of		nd Mental			12 0150
Physicia		Registrar 1. Decedent's Name (First, I	/liddle,Last)		imouto o			2. Date of Dea		3. Time of Death
ical Exami		Oliver Tho		dson				Month January 4		0709 hrs
)		4a. Facility Name (if not inst 5301 Deal Drive	tution, give street an	d number)		4b. City, Town, or Oxon Hill	r Location of De		4c. County of De Prince Geo	rge's
Funeral Director		5. Social Security Number 579 - 64 - 0704	6. Sex	7. Age (In yrs. Ia	ast birthday) Yrs	If Under 1 Yea Months Day			1,1948	Birthplace (State or reign DC Country)
	ı	Usual Residence of Decede	nt							10d, Inside City Limits
und show any nce.	١	10a. State 10b. Co MD Pri	_{inty} .nce Geo:		Town or Locat					1 Yes 2 No
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shomatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 671 Audrey	Lane	•		10f. Zip Code 20745			10g. Citizen of What 0	Country?
eath with items 23.	Funeral	11. Marital Status 1 Never Married 2	Married Arm	Decedent Ever in U. ed Forces? res 2 x No	S. 13. Wa	as Decedent of Hi es, specify Cuba	ispanic Origin? ın, Mexican, Pu	(Specify Yes or N erto Rican, etc.)	0- 14. Race - Ar White, et	
after d	by F		Divorced If Yes, Giv or Dates:	e Year		Yes 2 X No			Specify:	Black
hours natur	ed k	15. Decedent's Education				nt's Usual Occupa nost of working life			16b. Kind of Busine	ess/Industry
215-0036 be filed within 72 latal Hygiene. rked other than "ent, the Medical I	Completed	Elementary/Secondary (0		ge (1-4 or 5+)	Carpe	enter			Self En	nployed ——————
Hygi Hygi	ပ္	17. Father's Name (First, M James Odel		n				ame (First, Middle, L Richa)		
212 212 ould be Menta marke	To Be	19a. Informant's Name/Rela			19b. Mailin	g Address (Stre	et and Number	or Rural Route Nu	ımber, City or Town, S	tate, Zip Code)
MD 12 shouth and 1 and 1 is numatic		Jermaine S			671	Audrey	Lane (Oxon Hi	ll MD 207	745
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed with Department of Health and Mental Hygiene. Important: If item 27 is marked other it injury or other traumatic event, the Med		20a. Method of Disposition 1 Burial 2 Cren	nation 3 Remo	20b.	crematory or of		0	Date 1/16/20	20c. Location - Cit 1 2 Rivero	y or Town, State dale MD
Itim it. Pa urtmen urtmen ortant		4 Donation 5 Oth 21. Signature of Funeral Se	er Specify:	JR1	22	Le Crem	ss of Facility			20019_
Depa Depa		r								ningtonDC
Physician	П	23a. Part I. Enter the diseas								Approximate Interval Between Onset and
Medical Examiner		Immediate Cause (Final dis or condition resulting in dea	ease a. Hype	rtensive of as a consequence of	Gardiev			vascular	Disease	Death
		Sequentially list conditions	b							
	ine	if any, leading to immediate cause. Enter Underlying C	ause	ras a consequence a	11)					
pe ed	Examine	(Disease or injury that initial events resulting in death)		r as a consequence o	of):					
e executed sian and sial - trans	dical	UNPENDED	a. AMENI	23a,27, ₁	per me,	g925 3-8	3-12 sm			
60, tte be hysicie e buriz	Medi	IF FEMALE:		yes, outcome of preg		<u>25 3-22-</u>	·12 vt		23d. Date of del	ivery
BOX 6876U, death certificate be the attending physici of for use as the burn	Physician/Me	23b. Was decedent pregnar past 12 months?	t in the 1 🔲 l	ive birth Pregnant at time of de	2 F	etal death 3	Ectopic pr	egnancy	Month	Day Year
BOX death he atte	ysic	1 Yes 2 No 9		Jnknown						
F.O. s that the gned by t e detache	by	Part il. Other significant c	onditions contribut	ting to death but not r	resulting in the	underlying cause	given in Part I		tobacco use contribut es 2 No 3	e to the cause of death? Probably 4 Unknown
ds, equire	Completed							24a. Wa	s an 24b. Wer	e autopsy findings available to completion of cause of
e law r e has t ge 2 sh	mpl								formed? dear	
inn: The		25. Was case referred to m	edical		-30	26.Pla	ce of Death (Ch			
Vita ysich his cer direct	o Be	examiner? 1 ✓ Yes 2 N	Hospital: 1	Inpatient 2	ER/Outpatier	it 3 DOA	Other N	lursing Home 5	Residence 6	Other: Scene
n of ding Ph	-	27. Manner of Death 1 X Natural 5	28a.	Date of Injury (Month, Day,Year)	28b. Time of	· · · · · · · · · · · · · · · · · · ·	jury at Work? Yes 2 No	- 1	e how injury occurred	
Division of Vital Records, to a Attending Physician: The law requir state death. As the this certificate has been s led in by the funeral director, page 2 should I	Certification:	2 Accident 3 Suicide 6	Pending Investigation Could not be	. Place of Injury - At h	nome, farm, stre					or Rural Route Number, City
Division of Vital Records, P.O. Box 68760, To the Respital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Function: After this certificate has been signed by the attending physici completely filled in by the function, page 2 should be detached for use as the burit		4 Homicide 29a. Certifier 1 Certify	ing Physician: To the	ecify) ne best of my knowled	dge, death occi	urred at the time,	date and place	, and due to the ca	use(s) and manner as	stated.
o the ithin 2 o the omplet	Medical	one) 2 Medica	i Examiner:On the b	pasis of examination and stated.	and/or investig	ation, in my opinio	on, death occur	red at the time, da	te and place, and due	to the cause(s)
FRES	Me	29b. Signature and title of					nse number			(Month, Day, Year)
7		funite!	Hethelli.	mo		0.0	C.M.E.		January 5, 20)1Z
		30. Name and address of p Pamela E. South		d cause of death (Iter tant Medical Ex	_{m 23a)} aminer 90	00 W. Baltimo	ore Street, E	Baltimore, MD	21223	
S	tate			Registrar's Signa		-				
Regis		JAN 2 4	2012	we &	face	1				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 12:05 PM January Ronald Lester Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Baltimore 216 Northway Road Reisterstown 8. Date of Birth (Month, Day, Yes April 30 . Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign Months Days 1 🛛 M 2 🗆 F Hours Min. Country) Maryland Director 216-30-1046 78 Usual Residence of Decedent ms 23a or 28a-f show must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 216 Northway Road USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 14 Bace - American Indian þ 1 Never Married 2 Married X Yes Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) Ō2 Tool and Die Maker Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Charles Wagner Elizabeth Velton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice Lynn Wagner/Wife Northway Road, Reisterstown, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o Burial 2 ☐ Cremation 3 ☐ Removal from State
 Denation 5 ☐ Other (Specify) Jan 21,2012 Reisterstown, MD All Saints Cemetery Sign pre f in rahService Icens Bryan W. Clary 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley Inc.
10 W. Padonia Road. Timonium, MD 21093 23a. Part 1. Phter ne disease, or complications that caused the death. Lo not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Ph_sician/ disease or conditi resulting in death) U Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injuly that initiated events Examine Due to (or as a consequence of) and resulting in death) Last Due to (or as a consequence of) burial-1 attending physician for use as the buria Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No for Month Pregnant at time of death Day Year the 9 Unknown g Unknown P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

1 Yes 2 X No upleted filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) s after death. Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 🗌 Yes 2 🗌 No 1 X Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined To the Hospital o within 24 hours af To the Funeral Di completed filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Sertifying Nurse Practions. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

ucesa

114

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Patrick Turnes,/MD

20806

Business Center Drive, Reisterstown, MD 21136

January 24, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 2 per doc 9923 2-1-12 yt State of Maryland / Department of Health and Mental Hygiene State Registrar Reg. No.2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 14 Day 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and 4c. County of Death **Examiner** 4b. City, Town, or Location of Death If Under 1 Year 8. Date of Birth

(Month, Day, Year)

June 26, 195 **Funeral** Age (In yrs. last birthday 9. Birthplace (State or Foreign 1 M 2 D F Country) **Director** Usual Residence of Decedent shov 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland **Funeral Director** or 28a-f be notified 1 Yes 2 No τMO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 700 items . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc. 0 Completed by 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. "natural", 3 Widowed 4 Divorced Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) tution Iran Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Nu Wiggins 20a. Method of Disposition 20b. Place of Disposition (Name of cemeter, Gematory or other place) 20c. Location - City or 1 🗆 Burial 2 🖫 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 21. Sign of Funeral Service Lic Name and Address of Facility also 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiag shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician | disease or condition resulting in death) none Medical Due to (or as a consequence of) **Examiner** Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner (or as a consequence of) attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth
4 Pregnant a
9 Unknown 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Other (specify) Day Yea 1 Yes 2 L 9 Unknown this certificate has been signed by the an director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? To Be Completed by 2 No 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 □ Yes Certificate: 28d. Describe how injury occurred Natural injury 5 Pending 2 🗌 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

JAN 2 4 2012 State Registrar

12-00416 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #12 State of Maryland / Department of Health and Mental Hygiene Gary Richard Williams 2012 01507 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day January 14, 2012 **Medical Examiner** 1915 hrs Gary Williams Richard 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 38 Cobber Lane **Raltimore** 5 Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Months Days Min Director Hours 212-60-4938 1X M 2 F 57 04 15 54 Country) MD Yrs Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 No MD NA Baltimore with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 38 Cobber Lane 21229 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married 1XX Yes Pages 1 and 2 should be filed within 72 hours after treen of Fleuth and Mental Hygene.
 Trans: If item 27 is marked other than "natural", of yor other traumatic evect, the Medical Examiner. If Yes, Give Year or Dates: 3 Widowed 4 Divorced 1 Yes 2 X No specify: Specify: Black 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 llthgrade na Laborer Moving Company 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Harold Williams Anna Parker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dolores Parker-Aunt 38 Cobber Lane, Baltimore, Md 21229 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State King Memorial Park! ./24/2012 Woodlawn, Md 4 Donation 5 Other Specify: 21. Signature of Funeral Service Qicenses 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, 21215 Baltimore, 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line Between Onset and /Medical Death Immediate Cause (Final disease a Narcotic and Alcohol Intoxication Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate Examine cause Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical signed by the attending physician be detached for use as the burial X UNPENDED \Box AMENDED 23a, 27, 28a-f, per me, g924 2-3-12 sm Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy 2 Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. ۵ 1 Yes 2 ✓ No 3 Probably 4 Unknown pleted ficate has been s, page 2 should b 24a Was ar 24b. Were autopsy findings available prior to completion of cause of certificate has Comi performed? death? ✔ Yes 2 No 1 🗸 Yes 2 No To the Hospital or Attendiog Physician: within 24 hours after death.

To the Fuoeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 X No unknown fd 1-14-12 fd 7:10 pm 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City or Town, State) 38 Cobbler Lane. 3 Suicide 6 X Could not be determined Residence 4 Homicide Baltimore, Md 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal

DHMH 17 Rev 1/2001 **OCME 2006**

State Registrar

. Registrar's Signature

and manner stated

30. Name and address of person who completed cause of death (Item 23a)

OCME

29b. Signature and title of certifier

Laron Locke MD. 31. Date filed (Month, Day, Year)

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

January 15, 2012

Wilson, John Stanley

			ı	_				delible Inl			-		_	ble.		
		1	For State Registrar	5	state of	Marylan		artment of F tificate of D		and IV		giene Reg. No	Ω	12	n	1508
			Decedent's Name (First,	Middle, Last)							2. Date of De	ath		V	3. Time	of Death
6	Physicia Medic	_	John Stanl								Month JANUAF		20 20	Year) 1 2	2:3	38 A ^M
	Examin	er	4a. Facility Name (if not inst				CENIMI	4b. City, Town, or		f Death WSO	N	40	BAL		RE	
	Funeral		5. Social Security Number	6. Sex		Age (In yrs. I		If Under 1 Year Months Days	If Under 2		8. Date of Bir (Month, Da			9. Birthpl Countr		e or Foreign
	Director		218-40-1505 Usual Residence of Deced		12 🗆 F	69	Yrs.				8/4/19				/land	Į.
	yland f shov ed at	ğ	10a. State 10b. C				y, Town or Loc	cation						10		City Limits
•	r 28a- notifie	Direc	Maryland B 10e. Street and Number	altimore	<u> </u>	<u> </u>	owson	10f. Zip Code				10a C	itizen of W	hat Count		res 2 XXNo
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	1614 Feldbro	ok Road				21286					S.A.	nat oount	ıy.	
	death ritems iner m	Fun	11. Marital Status		Was Decede Armed Force	es?	S. 13. V	Vas Decedent of H f Yes, specify Cuba	ispanic Orig In, Mexican	in? (Spe , Puerto	cify Yes or No- Rican, etc.)			- America		
920	s after ral", or Exami	ed by	1 Never Married 2 5 3 Widowed 4 Div		1 Yes 2 If Yes, Give Year or Date:		1	☐ Yes 2 🛣 No	Specify:				Specify:	Whit		
2-0	2 hour "natur	Completed	15. Do (Specify only	ecedent's Educat	tion ompleted)		(Give I	lent's Usual Occup	during most	of worki	ng	16b. ł	Kind of Bus	siness/Ind	ustry	
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Maryland 21215-0036	filed wall Hyg		17. Father's Name (First, Mi								e (First, Middle,	Maiden				
ryla	uld be I Ment marke natic e	욘	John Stanley								nes War					
	12 sho Ilth and 27 is r r traur		19a. Informant's Name/Rela			fρ		ig Address <i>(Street a</i> Fe1dbrook								
Baltimore,	of Hea of Hea fitem rothe		20a. Method of Disposition 1 X Burial 2 Crem			20b. F	Place of Dispo	sition (Name of			Date	20c. L	ocation - 0	City or Tov	wn, State	
tim	t. Page tment tant: I		4 Donation 5 O		noval from St	Lo Lo		ark Cem.			/2012		altim			
Bal	permir Depar Impor any ir		21. Si	nytce licensoe	M	hi		. Name and Addres								nc.
-	Physician/		23a. Part 1. Enter the disea shock, or heart failure Immediate Cause (Final disease or condition	ase, or complicat List only one ca	use on each	line.		er the mode of dyin	- ,	_	r respiratory ar	rest,		1	Approxin Interval E	Between
-	Medical Examiner		resulting in death)		Due to (or	as a consequ	uence of):	10								
		iner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying	b. =	Due to (or	as a consequ	uence(o):									
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0	be exercian	ical	rooming in obatily basi	d												
68760	tificate ng phy e as th	Med	IF FEMALE:													
. Box 6	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		23b. Was decedent pregnar in the past 12 months? 1 Yes 2 No 9 Unknown		If yes, outcor 1 ☐ Live Bir 4 ☐ Pregnar 9 ☐ Unknov	th 2 🗌 Feta nt at time of a	al death 3	Ectopic pregnand Other (specify)	су				23d. Date Mon	e of delive th	ry Day	Year
ds, P.O.	quires that t en signed b ould be deta		Part II. Other significant co	<i>(</i>)	outing to dear	,	0	nderlying cause giv	ven in Part I		23e. Did t		use contrib			of death?
Records,	sician: The law rer certificate has be lirector, page 2 sh	Completed by					U		_		24a. Was auto perfo 1 \sum Yes		7 pi	ere autoprior to coneath?	npletion o	gs available of cause of
ital	Physician: T r this certifica eral director, p	Be	25. Was case referred to me examiner? 1 ☐ Yes 2 ☑ No	edical Hosp	oital:			Oth	ace of Deat							
of Vital	ding Phys h. After this funeral d	e: 70	27. Man er of Death		28a. Date of		ER/Outpatien 28b. Time of	28c, Injun	<u>4 ∟ Nu</u> yat		me 5 🗌 Resi 28d. Describe I					
ion	tendin leath. tor: Aft the fu	Certificate:	2 Accident	Pending nvestigation Could not be			injury		Yes 2	-						
Division	Il or At after o Direct d in by	Cert		determined 2		Injury - At ho , etc. (Specify		eet, factory, office			28f. Location (City or Tov			or Rural i	Route Nu	mber,
L	To the Hospital or Attenc within 24 hours after deatt To the Funeral Director; completely filled in by the	Medical	(Check 2 Dec	dical Examiner:	On the basis	of examination	n and/or invest	occurred at the time igation, in my opinio death occurred at t	on, death oo	curred at	the time, date a	and place	e, and due	to the cau	se(s) and	manner stated.
	To t with To 1		29b. Signature and title of c	ertifier	l	Nn	M	29c. License D trint)	304	33		29d. Da	ate signed N 20	(Month, D) 12	-
1	bV		30. Name and address of po	NO GA	M C	of death (Item	23a) (Type, P	haus	Stre	el	Ball	im	ore	Ma	21	204
	Stat Registra		31. Date filed (Month, Day,) JAN 2	(ear) 2012	3 Regi	strar's Signa	. pa	Kel			ę					
DHI	4H 17 Pay 06 0	011			-		-									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ FREDERICK 6:19 ALEXANDER YOUNG 2012 2 Ó Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner MEDICAL BALTIMORE VA BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, **Funeral** Hours Country 215.52.2589 Director MD 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Examiner must be notified at Director Battimore MD 1 ¥ Yes 2 ☐ No 10f. Zip Code 10g. Citizen of What Country? 0 10e, Street and Number Mayfield or items 23a Funeral LISA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, was Decedent Ever Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates. Black White etc ģ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Black "natural", Completed 3 Widowed 4 Divorced other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) nd Mental Hygiene. marked other than Heath Care Elementary/Secondary (0-12) College (1-4 or 5+) Technician Janitorial Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kosie Holmes Leroy E. Young July 1 and 2 shu July 2 shu July 2 shu July 2 shu July 3 shu July and is m 19b. Mailing Address (Street and Number or Ruţal Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship Alpe, Print) Sean L. Young Chemilane Laurel MD 20707 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 01/30/2012 Owings Mills, MD Garrison Forest V 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vallann C. Greene Funeral SVCS Read Randaustown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death ARREST to atherosclerotic - h, sician/ CARDIAC disease or conditi resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine One foliar as a nonsequence of) cause. Enter Underlying Cause (Disease or injury that initiated events that the death certificate be executed and burial-tran Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical Box 68760 attending p IE FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) 1 Yes 2 g 9 Unknown the P.O. I signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an the Hospital or Attending Physician: The law in 24 hours after death.

The Funeral Director: After this certificate has Empletely filled in by the funeral director, page 2 s autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ဂ္ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 Natural 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 🖳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

To the I only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 125738 Jan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ZARBALIAN 10 N. CREENE STREET BALTIMORE MO 21201 31. Date filed (Month, Day, Year) State **JAN 2 4** Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 18, ^{Day}012 Jan. Physician/ 4:12 A Margaret Louise Young Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Largo ManorCare g. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** April 13 1 🗆 M 2 🄀 F Months Hours Min. Indiana 1920 Director 307-16-9576 91 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 No MD Prince George's Cheverly 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? ò Funeral 23a and 2 should be filed within 72 hours after death with 20785 USA 3112 Parkway items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces?
1 ☐ Yes 2 🛣 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married ō δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: White "natural", 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Own Home 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Retha Pearl Burrows Marcus Edmond Exline 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 1077 Largo Road, Apt. 314, Upper Marlboro, MD 20774 Doris J. Mayes / Sister other 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of H Important: If ite any injury or ot Page 1 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State 4 Donation 5 Other (Specify) Maryland Veterans Cemetery 1/26/2012 Cheltenham, Maryland 4739 Baltimore Ave. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility las idette & Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death of not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition Ph_sician/ Aspiration Pneumonia Medical resulting in death) Due to (or as a consequence of): Examiner Dysphagia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exam Cause (Disease or iinjury that initiated events Dementia resulting in death) Last Due to (or as a consequence of): burialphysician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the attending IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 L Fetal Geal Pregnant at time of death Live Birth 2 - Fetal death 3 Ectopic pregnancy 5 Other (specify) ____ 3 in the past 12 months?
1 ☐ Yes 2 🔀 No
9 ☐ Unknown for Month Day Year 9 Unknown the detached à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Pleural Effusion Completed been 24b. Were autopsy findings available prior to completion of cause of 24a, Was an Bilateral Lower Extremity Cellulitis has autopsy perform death? Yes 2 X No 1 Yes 2 No 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner?
1 Yes 2 No Other: 4 🖾 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ After this 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28d. Describe how injury occurred Certificate: s after dea... ral Director: After 1 🔀 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide thin 24 hours after de the Funeral Directo mpleted filled in by ti 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

within 2

To the I

comple ၉

Darcy Ibitoye, 31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifie

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

12200

29c. License number

D51437

Annapolis Road, #232, Glenn Dale, MD 20769

29d. Date signed (Month, Day, Year)

January 20, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Hyun Nam Yoo 6:30 A. M 20,2012 January Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore County Timonium 2418 Burlwood Road 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days 1 M 2 X F Months Hours Min None , 1924 South Korea 87 **Director** March Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits with the Maryland at Director notified 1 Yes 2 No Baltimore County Maryland Timonium 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 2418 Burlwood Road 21093 Korea items Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 No Examiner Black White etc. 9 δ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Korean Specify "natural" 3X Widowed 4 ☐ Divorced Completed Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired Elementary/Seconday (0-12) 06 College (1-4 or 5+) **N/A** the Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers is marked or ပ unknown Kim Kyung Jong Yoo traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other trau once, Timonium, Maryland 21093 2418 Burlwood Road Mr. Hyun Sung Lee (Son) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date · Location - City or Town, State (Baltimore County) 1 A Burial 2 Cremation 3 Removal from State Dulaney Valley Men. Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Jan. 23, 2012 Gardens of Funeral Service License Teffrey L. Gair, Sr. OFS 22 Name and design of Family lives Funeral and Cremation Center, P.A. Lic.#M00677 2325 York Road Timonium, Maryland 23a. Fort 1. Interthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on e. ch line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to lor as a conse uence of attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physicis P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death been signed by the a should be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No page 2 1 Yes 2 No funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be P Other: 4 Nursing Home 2 **1** No 1 Tes ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 1 Inpatient 2 I 28a. Date of injury (Month, Day, Year) 27, Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No 2 Accident Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suiciae 4 ☐ Homicide 28f. Location /Street and Number or Rural Route Number. determined City or Town, State) Medical 29a. Certifier 🗗 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сотріете within 2 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number cause of death (Item 23a) (Type, Print)

State

Registrar

JAN 2 4 2012

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 29d per me g924 2-16-12 yt
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month January 2012 Physician/ A^{M} 1:57 Yingling Katherine Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Towson Gilchrist Hospice If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** 04/07/1922 Mary land 1 M 2 X F Months 89 **Director** 216-14-4169 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location notified at Director 1 🔀 Yes 2 🗌 No MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number ms 23a or must be r Funeral U.S.A. 21037 9126 Philadelphia Road permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 Never Married 2 Married Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify. Completed 3 X Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Schmidtman Katherine Harry Sanft 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 205 Seagull Drive, Havre de Grace, MD 21078 Karen Utter / Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Anatomy Gifts Registry 01/23/2012 Hanover, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between set and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner ZV Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to for as a consequence of burial-transit Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death signed by the at d be detached for Yes Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by reproperious 1 Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an 24 hours after death.

Funeral Director, After this certificate has I autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 🗌 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Jawany 13 Zeiz 28d. Describe how injury occurred **probable fall** 27. Manner of Death 28b. Time of 28c. Injury at Medical Certificate: injury work? 1 Natural 5 Pending Accident Suicide VAL M Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 9126 Philanolphia RD, Beltmere m) home Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 ho

To the Fune

completed fi (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 the only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 58303 20 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 6701 N-(CHANCES ND no TOWSON istrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 20°, 2012 8:14 AM January Nancy Zavilinsky Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner Bethesda** Montgomery Suburban Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) **Funeral** Hours Min. (Month, Day, Year) 203-30-8576 **Director** 1 🗆 M 2 🗶 F 73 Pennsylvania May 13, 1938 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County must be notified at 10c. City, Town or Location Director 1 Yes 2 No Chevy Chase Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 23a Funeral 20815 United States 8411 Lynwood Place ral", or items 2 Examiner mus death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc. 1 X Never Married 2 Married þ Yes 2 X No Maryland 21215-0036 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: "natural", White 3 Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the Nursing Home 5+ Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Kendra Frank Zavilinsky other traumatic and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) l and 2 s Health s tem 27 i 8411 Lynwood Place, Chevy Chase, Maryland 20815 Vicky Zavilinsky / Sister Department of Healt Important: If item 2 any injury or other Baltimore, 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition January 2012 20c. Location - City or Town, State 1 X Burial 2 \square Cremation 3 \square Removal from State 4 \square Donation 5 \square Other (Specify) 25 Silver Spring, Maryland Gate Of Heaven Cemetery 21. Signature o x un run Service Licensee Robert A. Pumphrey Funeral Home, Bethesda-Chevy Chase, Inc. M01619 7557 Wisconsin Avenue, Bethesda, Maryland 20814 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Atherosclerotic Cardiovascular Disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exam that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical attending properties for use as Division of Vital Records, P.O. Box 687 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death Yes 2 X No the detached 9 Unknown g Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? þ page 2 should be Hypertension, Type 2 Diabetes Mellitus, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? Hyperlipidemia 24a. Was an has autopsy performed? Yes 2 X No certificate l 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 【 No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify Hospital: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DQA ပ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 X Natural 5 Pending injury n 24 hours auer de he Euneral Director. Afte 1 ☐ Yes 2 ☐ No Investigation Accident 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [the only one) within To the

State

DHMH 17 Rev 06-2011

31. Date filed (Month, Day, Year)
JAN 2 4 2012 Registrar

32. Registrar's Signature

mi

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Convell

D WISCONSIN

29d. Date signed (Month, Day, Year)

Ste

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Joseph Antoniak Jahuary 23 2012 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Baltimore Examiner 4b. City, Town, or Location of Death Stella Maris Timonium Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 219-12-9051 March 31 Pear 1925 **Director** 1 X M 2 F 86 ms 23a or 28a-f show must be notified at 10b. Count 10c. City, Town or Location Director Maryland Baltimore Towson 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 7515 Far Hills 21286 U.S.A. Drive 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☑ Yes 2 ☐ No
If Yes, Give 1943-1946
Year or Dates . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, other traumatic event, the Medical Examiner Black, White, etc 1 Never Married 2 Married þ 21215-0036 1 ☐ Yes 2 X No Specify. "natural", Completed 3 🛚 Widowed 4 🗆 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) than " Elementary/Secondary (0-12) College (1-4 or 5+) Office Manager Finance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Alexander Antoniak Susan Misiuk 19a. Informant's Name/Relationship (Type, Print) l 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Page 1 and 2 siment of Health ant; If item 27 i Parkville, Maryland Michael Antoniak / Son 3204 Sperl Court Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1.
Department of I Important: If it any injury or or once, 1 X Burial 2 Cremation 3 Removal from State Holy Trinity Cemetery 1/28/2012 Elkridge, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Ruck Towson Funeral Home, 1050 York Road Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician/ PANCREATIC CANCER Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş To the Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed JOSEPH 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performe death? certificate 1 Yes 2 No Yes 2 X No Certificate: To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) this 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 🗶 Naturai 5 \square Pending within 24 hours area.

To the Funeral Director: Aftr __ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

X Contributing Nume Fractitioner: To the best of my knowledge, death occurred at the fine, date and place are close to the name as a false. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CRNP 2300 DULANEY VALLEY RD. JUNECIA WHITE. TIMONIUM, MD 21093

4:28 P

10d. Inside City Limits

1 Yes 2 No

9. Birthplace (State or Foreign

Maryland

White

21204

Onset and Death

Year

DHMH 17 Rev 06-2011

State Registrar JAN 2 5 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2012 12:1⁵ PM Physician/ Jan Maureen R. Bowers Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year, Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 214-82-7015 1 □ M 2 🔀 F 51 Director 12-27-60 MD Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10c. City, Town or Location 10a. State aţ Director ral", or items 23a or 28a-f s Examiner must be notified Davidsonville 1 Yes 2 XNo MD Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 3686 Nile Rd. 21035 USA ould be filed within 72 hours after death v nd Mental Hygiene. marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2X No Black, White, etc. 1 Never Married 2 Married "natural", or þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: White Completed 3 Widowed 4 Divorced other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Appraisel Office Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lillian A. Pearson John E. Shanahan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S. . Page 1 and 2 sh tment of Health a tant; If item 27 is 3686 Nile Rd., Davidsonville, MD 21035 Gregory A. Bowers-husband 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a Method of Disposition permit. Page 1 Department of Important: If it cemetery, crematory or other place) 1 Burial 2X Cremation 3 Removal from State South Carroll Crem 1-24-12 Sykesville, MD 4 Donation 5 Other (Specify) 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Fletcher Funeral Home 254 E. Main St., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final metastatic Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and I for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day Other (specify) Pregnant at time of death signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, plnous Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate b 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 1 Natural 28d. Describe how injury occurred 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nupse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and of certifier 29c. License number 29d. Date signed (Month, Day, Year) M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , 2001 Medical PARKWAY 31. Date filed (Month, Day, Year) State

Registrar

5

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Reg. No. U Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month Day 2012 Physician 24 Jan. 3:50PM Gertrude Bertha Baker /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a Fecility Name (If not institution, give street and number) Examiner Carroll 250 St. Luke Cir. Apt. 713 Westminster If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04/24/1920 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Days Hours 1□ M 2□ F 149-07-2543 91 Vrs Director NJ Usuat Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural: or Maryland page." 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MD Carroll Westminster 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 250 St. Luke Cir. Apt. 713 21158 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes È No If Yes, Give Year or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Never Merried 2 ☐ Married 1 Yes 2 No Specify: Specify: White ģ 3 Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Education Teacher Aide 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clarence Heerema Gertrude Hagedorn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 222 Mildtead Rd. Newport News, VA 23606 Ellen Whiting-daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Scremation 3 Removal from State 1/25/12 Sykesville 4 ☐ Donation 5 ☐ Other (Specify) South Carroll Crem 22. Name and Address of Facility Fletcher Funeral Home, P.A 21. Signality & Funeral Service Licensee 254 E. Main St. Westminster, MD 21157 he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician mentia - severa End stage Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner or Attending Physician: The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Division of Vital Records, P.O. Box 68760. Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 🚧 No 3 ☐ Probably 4 ☐ Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? ak No 1 ☐ Yes 2 ☐ No 1 Ves 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident Director: / 6 ☐ Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by To the Hospital within 24 hours a To the Funeral C 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. 29a. Certified Medical 29d. Date signed (Month, Day, Yeer) 29b. Signature and title of certifie 29c. License number eted cause of death (Item 23a) (Type, Print) W25/minster, Md. 2/158 31. Date filed (Month, Day, Year)

JAN 2 5 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Laverne Bailey nuari Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death 4c. County of Death **Examiner** N/A Gieneral altimore lar 8. Date of Birth If Under 1 Year If Under g. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days (Month, Day, Year) Sep 15, 1946 1 M 2 XF Months 1 4 1 Hours Min. Country) MD 65 212-48-0735 Director Usual Residence of Decedent shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental "ygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f shor 10a. State 10d. Inside City Limits 10c. City, Town or Location Director notified 1 Yes 2 No **Baltimore Baltimore City** MD 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code permit. Page 1 and 2 should be filed within 72 hours after death with th Department of Health and Mental "ygiene. Important: If Item 27 is marked other than "natural", or items 23a o any injury or other traumatic event, the Medical Examiner must be Funeral U.S.A. 21217 1701 Eutaw Place Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?
1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black If Yes. Give Specify. 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Retail Salesperson 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mable Ricks **Thomas Bass** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2557 West Lafayette Avenue Baltimore, MD 21216 Dawn Ricks 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State Windsor Mill, Md. Jan 11, 2012 5 Other (Specify) King Memorial Park 22. Name and Address of Facility **Estep Brothers Funeral Service, P. A.**1300 Eutaw Place Baltimore, Md 21217 21. Signal in Licent 23a. Part 1/5 her the disease, or complications that caused shock or heart failure. List only one causi on each line. Immediate Cause (Final he death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between peration Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine to for as a consequence of, signed by the attending physician and I be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3

Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ဂ 1 Yes 1 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending death. 1 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number

nown Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician; The law requires completed filled in by the funeral director, page 2 should within 24 hours after deat To the Funeral Director, Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. State Registrar DHMH 17 Rev 7/2009 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Jake Bellamy, III 11:59a Jan 12, 2012 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 501 Dolphin Street **Baltimore** N/A 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Months 1 M 2 □ F Hours 243-50-7092 Director 76 NC Mar 9, 1935 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 1 X Yes 2 □ No Director MD **Baltimore City Baltimore** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Iral", or Items 23a or Examiner must be r 501 Dolphin Street 315 21217 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give 1x Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2x ☐ No Specify: Black Completed by 3 Widowed 4 Divorced Year or Dates: er than "natur , the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Construction **Private Company** 12 Item 27 is marked other other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jake Bellamy Jr. **Bessie Lee Williams** ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Morticia Burton 1628 West Lexington Street Baltimore, MD 21223 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 'Department of H Important: If Ite any Injury or of **X**☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Jan 19, 2012 Lansdowne, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion Cemetery 21. Signs ture of Functal Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final VATURAL CAUSES **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner CALDWASCYLAN ATHERD SCLENOTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 Fetal death 3 Ectopic pregnancy Month in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 🕰 Residence 6 ☐ Other (Specify) Hospital: 1 X Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 😿 Certifying Physician; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature and title of certifier

EMMANUEL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KYEREME-

LINDEN AUTHOR

527

29c. License number

29d. Date signed (Month, Day, Year)

2012

JANUARY

BALTIMARE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 22 per fh e923 1-25-12 vt
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ January Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Death aurel Regional ospita _dure | Prince Georg Social Security Number 1 Year If Under 24 Hrs. If Under Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, 250-34-3941 1 🗆 M 2 🛛 F Months Hours 87 **Director** South Carolina Nov. 1924 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's Fort Washington 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 507 Hadrian Lane 20744 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give Year or Dates Specify: Completed 3 X Widowed 4 Divorced Black the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. V.A. Hospital Elementary/Seconday (0-12) College (1-4 or 5+) Dietitian of Buffalo Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jollie Short Fannie Emmanuel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 507 Hadrian La., Fort Washington, MD 20744 Charles Brice Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Forest Lawn Cemetery 20c. Location - City or Town, State Date 1 🕅 Burial 2 🗆 Cremation 3 🗀 Removal from State Buffalo, NY 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Funeral Services 7 Vine S Signature Funeral Service Ligensee Alexandria, Va. 22310 Part 1. There the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ perKalemid disease or condition resulting in death) Medical Examiner ehydrati Sequentially list conditions, Physician/Medical Examiner if any, leading to immedicause. Enter Underlying Dementia Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month 4 Pregnant at time of death 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Comfort Care 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Acute Renal Failure 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death? 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?

1 Yes 2 No Hospital Other: 1 XInpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: Tonje best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only or 29b. Sign 0066284 7300 Van on who completed cause of death (Item 23a) (Type, Print) Malik, MD Laurel Regional Hospital Date filed (Month, Day, Year, State Registrar

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P hysiciar	ž/	1. Decedent's Name (First, Middle, Las	•			2. Date of _Month		year Year	3. Time of Death
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Examine	er	708 Raynor Avenu			Catonsv			Baltimore	
Funeral Director		223-42-0330	ex 7. Age	(In yrs. last birthday) 76 Yrs.		Jnder 24 Hrs. 8. Date of ours Min. (Month, Sept	Birth Day, Year 27, 1		lace (State or Foreign (y) inia
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a or 2	<u> </u>	10e. Street and Number			10f. Zip Code		10g. 0	Citizen of What Coun	try?
th with ms 23 must	Funeral	708 Raynor Avenue	10 Was Dansdort F	nu in 11 C 12	21228	in Origina (Specify Ves or I		S.A.	an Indian
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Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", o any injury or other traumatic event, the Medical Examone.		19a. Informant's Name/Relationship (T. Donna Fendlay (I	ype, Print) Daughter)			Number or Rural Route Nur Ave., Catons	ville	e, MD 2122	28
IMOre, I Page 1 and 3 nent of Healt ant: If item 2 ury or other		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □	Removal from State		matory or other place)	Date 1/21/2012		Location - City or To	
Baltimor permit. Page 1 Department of Important: If it any injury or o		4 ☐ Ponation 5 ☐ Other (Special Service Lice)	fy)	Memorial	Crematory			shersville	e, VA
Depert Depert any	-	21. Signature of Juneral Service Lice	Municipality		har Jun and blacknose Cr	Groome Fune	ral	Ville VA	matory 22939
		21. Signature of Juneral Service Lic-	plications that caused tone cause on each line.	the death. Do not en	ter the mode of dying, su	Alexandria ch as cardiac or respirator	y arrest,	22310	Approximate Interval Between
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cords, P.O. law requires that the has been signed by the s 2 should be detach	Completed by			7		24a. V		24b. Were autor	osy findings available mpletion of cause of
Rec The lar ate ha	Ę					р	utopsy erformed (es 2	death?	_
cian: certific	Be	25. Was case referred to medical examiner?	Hospital:		26. Place of	of Death (Check only one)	67		
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DIVISION OF VITAI RECORGS, lal or Attending Physician: The law requires 's after death. The law free this certificate has been sign in by the funeral director, page 2 should be in by the funeral director, page 2 should be in by the funeral director.	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur building, etc.	y - At home, farm, si (Specify)	reet, factory, office		on (Street a Town, Sta	and Number or Rural te)	Route Number,
Division of Vital Recc To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 v	Medical	(Check 2 Medical Exam	iner: On the basis of ex-	amination and/or inve	stigation, in my opinion, de	e and place, and due to the eath occurred at the time, da e, date and place, and due t	ate and pla	ce, and due to the cau	use(s) and manner state
Vithii Vithii Comp		29b. Signature and title of pertifier	^		29c. License nur			Date signed (Month, I	
					DE	35259	000	1118 90	13
2		30. Name and address of person who	completed cause of de	ath (Item 23a) (Type,	Print)	W BALL	Dos	2122	9
State		31. Date filed (Month, Day, Year)	32. Figistrar			V V			
Registra		JAN 2 5 2	0121 Au	~ B. A	rale				

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number)
Northwest 4b. City, Town, or Location of Death **Examiner** Baltimore Seasons Hospice at Randallstown Hospita1 If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number Age (In yrs. last birthday) **Funeral** 215-78-1238 1 □ M 2 🕱 F Director Yrs 52 September 6,1959 North Carolina Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10d. Inside City Limits 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 1 X Yes 2 □ No Baltimore Maryland None 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 517 Baltic Avenue, Apartment A 21225 <u>United States</u> 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify 3 Widowed 4 X Divorced Black. Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 11 Cashier Food Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Beatrice Robinson Abraham Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1169 Booth Bay Harbour, Pasadena, Maryland 21122 Howard A. Brooks, III/Son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date January 25 2<u>012</u> West Arunde 1 other place) Crematory 1 🗌 Burial 2 💢 Cremation 3 🗍 Removal from State Odenton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road, Odenton, Maryland 21113 Will Exponer M00672 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical (or as a consequence of) **Examiner** Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of) Cause (Disease or injury To the Hospital or Attending Physician; The law requires that the death certificate be executed the burial-trar that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnan Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ģ Year Month Day Pregnant at time of death
Unknown Other (specify) signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? 25. Was case referred to medical To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 🗌 Yes ER/Outpatient 3 DOA 1 Inpatient 2 After this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending after death. Director: Aft 1 Yes 2 No the Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Fune

completely fi 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 06-2011

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32. Registra

30. Name and address of person who completed cause of death (Item 23a) (Ty

3f. Date filed (Month, Day, Year)

JAN 2 5 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 30 am Booze Susie Dorothy Medical 4b. City, Town, or Location of Death Baltimore 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner 2611 Liberty Heights Ave If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday, **Funeral** Days (Month, Day, Hours Min 214-24-9188 MD Director 1 ☐ M 2🗓 F 84 or 28a-f show notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location Director Baltimore 1 X Yes 2 No NA MD 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ö "natural", or items 23a o U.S.A. Funeral 21215 2611 Liberty Heights Ave hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11 Marital Status Black White, etc. 1 Never Married 2 Married ò 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black 3X Widowed 4 ☐ Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Innportant: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. once. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) City Hospital Physical Therapist na 12th grade Be Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anna Bell Johnson 8:30 mm Louis Keene 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
514 Nassau Street, Pikesville, Md 21208 19a. Informant's Name/Relationship (Type, Print) Marshall Booze Jr-Son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 1/31/2012 Marriottsville, Md 4 Donation 5 Other (Specify) Crestlawn 22. Name and Address of Facility t March West 4300 Wabash Ave, Funeral Service License Baltimore, Md 21215 Jony 3a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if dry, leading to him rediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy Month To the Hospital or Attending Physician: The law requires that the death for in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 No been signed by the a should be detached f 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. b Dementia Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy perform has death? 1 ☐ Yes 2 ☐ No eral Director: After this certificate filled in by the funeral director, pag Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ျပ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work?
1 Yes 2 No Accident
Suicide Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a To the Funeral C 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my analysis of examination and/or investigation, in my analysis of examination and/or investigation. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certif 29c. License number M0064267 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Linden AV Back MD 21201 OUT INT BUTUN 27 31. Date filed (Month, Day, Year) 32. State Registrar

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Booze

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Bobbi+t Physician/ Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death **Examiner** Grantle NA Baltimore 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 06 9435 1 M 2 **Director** Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygene.
if then 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location Director Randallstown 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Numbe Place Apt. 2 Funeral ISA 21244 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black White, etc. Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 3 No Specify: Specify: Black If Yes, Give 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) onday (0-12) Callege (1-4 or 5+) Provider Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First_Middle, Last) permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type, Print) Sheldon Ave. Balto, Mb 21206 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Funeral Service Lanse 270 Fredhilton Pass . Signatur 22. Name and Address of Facility Earl P. March Funeral Home nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final Pnysician disease or condition Medical resulting in death) Due to (or as a consequence of): Examine Sequentially list conditions, Examine Due to (or as a consequence of). it any, leading to immediate cause. Enter Underlying signed by the attending physician and dedetached for use as the burial-transit The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live Birth 2 - Fetal death in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Completed within 24 hours after death.

To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 🗌 Yes the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) **Division of Vital** Be examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence မှ 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation
6 Could not be Accident
Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie address of person who completed cause of death (Item 23a) (Type, Print)

2411 West Belvedere State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 01524

		1- For State Registrar			Certifi	icate of	Death			- Re	eg. No.		
Physici ledical Exami		1. Decedent's Name (First, Middl		n Jam	es Bo					2. Date of Deat Month January 22	Day Yea 2, 2012		3. Time of Death 1727 hrs
		4a. Fecility Name (if not institution 217 Doris Avenue	n, give street and n	umber)		4	o, City, Town, or L Brooklyn	ocation of	f Death		4c. County of		-
Funeral Director		5. Social Security Number 212 08 6915	6. Sex 1X M 2 F	7. Age (I	n yrs. last t	birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min.		th(MM/DD/YYYY /1984		pplace (State or n _{try)} Maryland
uyland 8a-f show any at once,	or	Usual Residence of Decedent 10a. State 10b. County Maryland N/A		10	•	wn or Location							10d. Inside City Limits 1 X Yes 2 No
th the Maryland 23a or 28a-f sho	Director	10e. Street and Number 3901 - 4th S	treet				10f. Zip Code 2122	25		10	$_{0g.}$ Citizen of Wh $_{\bullet}$ S	ry?	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f she other traumatic event, the Medical Examiner must be notified at once	by Funeral		orced If Yes, Give Ye or Dates:	orces? 2 X ar	No	if Ye	Decedent of Hisp s, specify Cuban, Yes 2 X No	Mexican, specify:	Puerto R	ican, etc.)	White Specify:	, etc. Whi	
5-0036 ted within 72 hours tygiene. other than "natus	Completed	15. Decedent's Education (Spec Elementary/Secondary (0-12)	College (1-4 or 5+)	eted) 16a	during mo	s Usual Occupationst of working life. Lesman	DO NOT u	use retire	d)		ers	Furniture
21215-0036 uld be filed within 7 Mental Hygiene, marked other than c event, the Medica	B	17. Father's Name (First, Middle,	Peter	Bois					Nanc	y Cadd			
e, MD 21215 1 and 2 should be fill Health and Mental H item 27 is marked r traumatic event, i	٩	19a. Informant's Name/Relationsl Nancy Cadden 20a. Method of Disposition			Ť	217 Do	Address (Street Oris Ave: on (Name of cem	nue			ore, Mar 20c. Location -	y1ar	nd 21225
Baltimore, Permit. Pages 1 an Department of Hec Important: If ite		1 X Burial 2 Cremation 4 Donation 5 Other Sp	_	rom State	crem	natory or other	Cemeter	у	01/2	6/2012	Baltim	ore,	Maryland
			ruceou			400	1 Ritchi	le Hi	ghwa	y Balt		Mary	land 21225
Physician Medical Examiner		23. Part I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease	on each line. a. Combin	ed ef	fects		mode of dying, s cycodone					irt	Approximate Interval Between Onset and Death
	_	or condition resulting in death) Sequentially list conditions, if any, leading to immediate	b. Due to (or as a										
i i	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a		The second								
760, cate be executed physician and the burial - transi	/Medical E	X UNPENDED	d AMENDED 2	23a,p	t.II,	27,28	-f,per	me,g9	926 4	i-9-12	SM		<u> </u>
Box 68' death certifing a for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in th past 12 months? 1 Yes 2 No 9 Unk	I I Live I	oirth nant at tim	of pregnance	2 Feta	I death 3	Ectopic	pregnand	sy .	23d. Date of Month	delivery Da	ay Year
P.O. es that the igned by oe detach	ē	Part II. Other significant conditi		o death bu	it not result	ting in the un	derlying cause giv	ven in Par	t I.				ne cause of death?
cords law requ has been 2 should	Completed									24a. Was a autops perform	sy pi med? de		ppsy findings available mpletion of cause of 2 No
di di	Bec	25. Was case referred to medical examiner?	Hospital: 4				26.Place						
of Vita ing Physicia After this cer uneral direct	P	1 ✓ Yes 2 No 27. Manner of Death	28a. Date	of Injury		Outpatient Time of Injury					Residence 6	_	Scene
C # . ~ 2	ij	1 Natural 5 Pend	(Month	Day, Year)			1 V	s 2 🗶 I			overdos tion me		p.
Division To the Hospital or Attendi within 24 hours after death. To the Funeral Director: , completely filled in by the fi	Certification:	3 Suicide 6 Could	ligation	e of Injury	- At home,	15:20 j farm, street,	factory, office bu	ilding, etc.	. 2	8f. Location (S or Town, St		r or Rura	al Route Number City
To the Hospi within 24 hou To the Funer completely fi	Medical C	29a. Certifier 1 Certifying Ph	ysician: To the bes	of examina	owledge, d	death occurre	d at the time, date		e, and du	ue to the cause	e(s) and manner	es stated	
To with	¥.	29b. Signature and title of certifier	and manners	ialed.			29c. License				29d. Date signe		h, Day, Year)
		Mu Bra 30. Name and address of person			•		O.C.M				January 23	2012	
	ate	Melissa Brassell, MD 31. Date filed (Month, Day, Year)	Assistant Me	dical Ex		900 W.	Baltimore Sti	reet, Ba	itimore	, MD 2122	3		
Regist	_	JAN 2 5 2012	Benera	A	A	and de							
DHMH 17 Rev 1/20	001	OCME		1	70	RIGINAL							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#21perFH, G923, 1/2572012, WS

State of Maryland / Department of Health and Mental Hygiene 2011 2012 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 5:25 AM JANUARY 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death OF BALTIMORE SINAI HOSPITAL BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** 6. Sex 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign Days Hours Min. **Director** 18-86-888 1 1 M 2 N INI a 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland **Funeral Director** be notified 1 A Yes 2 No timore ō Street and Number 10e 10f. Zip Code 10g, Citizen of What Country? 23a items LON4 Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian. Examiner Black, White, etc. "natural", or 2 No 1 Never Married 2 Married þ 1 Yes 2 If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced Completed Blace Year or Dates I and 2 should be filed within 72 hour f Health and Mental Hygiene. Item 27 is marked other than "natu other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Mitchell OLTON. Elementary/Secondary (0-12) College (1-4 or 5+) LACE ourthouse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည rnantan 130h (int) 19a. Informant's Name/Relationship (Type, 19b. M. ling Address (Street and Number or Rural Coute Number, City or Town, State, Zip Co.) 3 21223 item 2 Date Method of Disposition

☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of artment of hortant: If ite Page 1 cemetery, crematory or other place) Donation 5 Other (Specify) MD permit.
Der antr
Imports
any inju 21. Signatu of Euperal Service Licensee Odyssey Gray ,22 Name and Address of Facility ped DVR 23a. Pal 1. Enter the lisease, or complications that cau did the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shipt, or hear failure. List only one cause on each lin.

Immediate Cause (Findisease or condition in death)

METASTATIC ADEANC. ADEANC. Approximate Interval Between Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) use as the burial-transit Cause (Disease or injury and that initiated events resulting in death) Last Due to (or as a consequence of): by the attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FFMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy After this certificate has been signed by the atte funeral director, page 2 should be detached for in the past 12 months? Month Day Year Yes 2 No 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HYPERTENSION 2 No 3 Probably 4 Unknown Completed 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 Tes 2 No Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No HOSFICE မ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 1 🔀 Naturai 5 Pending injury 2 Accident
3 Suicide Investigation filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitions: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check the 29b. Signature and title of certifie P 29c. License number 29d. Date signed (Month. Dav. Year) MO RES-000 JANUARY 19 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRIJEN JOSHI MD SINAI HOSPITAL OF BALTIMORE State 32. Registra s Signa Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ BRIDGE 05:12A M 2012 JAM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** BALTIMORE OWINGS MILLS 841 CRYSTAL PALACE COURT If Under Birthplace (State or Foreign Country) 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) **Director** 219-58-6320 1 M 2 X F 10/15/1955 56 NY Usual Residence of Deceden 28a-f show should be filed within 72 hours...
I and Mental Hygiene.
7 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location Director 1 ☐ Yes 2 🕅 No BALTIMORE OWINGS MILLS MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral 21117 841 CRYSTAL PALACE COURT Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🗓 No If Yes, Give Black, White, etc. by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: WHITE 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) OWNER MARKET RESEARCH Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 permit. Page 1 and 2 should be Department of Health and Ment. Important If item 27 is marken any injury or and KREITMAN THELMA ELIAS IRWIN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 841 CRYSTAL PALACE COURT, OWINGS MILLS, MD 21117 JEFFREY BRIDGE/HUSBAND Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) ARLINGTON CHIZUK AMUNO 1/23/2012 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature unu al Service Licensee 12 MD 21208 -8900 REISTERSTOWN ROAD, PIKESVILLE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Small Physician/ Lel 10 months disease or condition Medical resulting in death) Examiner Sequentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician the for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death 1 Yes 2 9 Unknown eral Director: After this certificate has been signed by the a filled in by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy 24h. Were autopsy findings available prior to completion of cause of death? performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \blacksquare Residence 6 \square Other (Specify) Hospital: ျ 1 🗌 Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death. To the Funeral Director: After injury X Natural 5 Pending 1 Yes 2 No Investigation Accident 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D0069329 M.D. MEI TANG e 201. Baltimore, MP 21204 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6569 N. Charles St. PPW Swi

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Suite 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2012 ear 7:15A M Harry Albert Chew Sr. Jan 23 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll 276 East Main St., Westminster Apt. 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Days Hours 220-16-2017 1 XM 2 D F 85 **Director** 10-23-1926 MD Usual Residence of Decedent or 28a-f show 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director Carroll Westminster 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21157 276 E. Main St., Apt. 2 USA filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married X Yes 2 No Maryland 21215-0036 1 Yes 2 XNo Specify Specify: white If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Maintenance Elementary/Secondary (0-12) College (1-4 or 5+) Truck Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fisher is marked o 2 Mary Tawney Page 1 and 2 should be Harry M. Chew other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $\,21157$ Department of Health as Important: If item 27 is any injury or other trau 276 E. Main St., Apt. 2, Westminster, MD Taulbee-daughter Joyce M. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Kurial 2 Cremation 3 Removal from State 1-27-12 Finksburg,MD Carrollton Church 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of uneral Service Licer 22. Name and Address of Facility Fletcher Funeral Home hithen. 254 E. Main St., Westminster, MD 21157 formal 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ A myotrophi disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): anemia れれいし attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death ed by the a detached f P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ nydration Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No After this certificate 1 Yes 2 No Hospital or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No 4 Nursing Home 5 Residence 6 Other (Specify, မူ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death To the Funeral Director: A Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 M. dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner 1. The best of ny included, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RO722 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day,

12-00445 Elfriede Claypool Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

friede Claypool	State of Maryland / Department of Health and Mental Hygiene 1-For State Amend Items 4a, 28e, f per ma 292 101/25/2012dhb Registrar Reg. No. Reg. No.	01528
Physician/ ledical Examiner	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 21	ne of Death 137 hrs
edical Examiner	Elfriede Charlotte Claypool 4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore	
		o (State or
Funeral Director	Months Days Hours Min. Foreign Country)	Germany
Director	Lisual Residence of Decedent	
any	10a. State 10b. County 10c. City, Town or Location 10d.	Inside City Limits Yes 2 No
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th the Maryland 23a or 28a-f sho notified at once.	TIC 7	
s 23a c notif	11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-	idian, Black,
or items 23	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc.	
s after ral", o	3 X Widowed 4 Divorced If Yes, Give Year or Dates: 15 Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done) 16b, Kind of Business/Industrial Completes 16b, Kind of Business/In	
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5-0036 ed within 72 hour lygiene. other than "natu the Medical Exan Completed	Unknown Crossing Guard Police Depar	tment
filed w d Hygic et the N	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Unknown	ıknown
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip C	
MD d 2 should be and	Patricia Whitney 5493 Woodenhawk Circle, Columbia, MD 21044	State
or Heal	1 Burial 2	, State
Baltimore, oemit. Pages 1 ar Department of He Important: Will minortant: Will minortant of the Important of I	4 Donation 5 Other Specify: West Arundel Crem. 01/20/2012 Odenton, MD	T. 3
Bai permit Depar injury	21. Signature of Funeral Service picensee 22. Name and Address of Facility Donaldson Funeral Home, M01581 313 Talbott Ave, Laurel, MD 20707	P.A.
Physician	23a Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart. App	proximate Interval etween Onset and
- Medical Examiner	Immediate Cause (Final disease a Head Injuries Intracranial Hemorrhage	Death
***************************************	or condition resulting in death) Due to (or as a consequence of):	
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68760 certificate l nding phys see as the bh	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day	Year
Si la at a la Si	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (Specify)	
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8 S S S	Atherosclerotic Cardiovascular Disease 1 Yes 2 No 3 Probably 24a Was an 24b. Were autopsy	
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To the Ho within 24 I To the Fu completely	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cau and manner stated.	
The state of the s	29b. Signature end title of certifier 29c. License number O.C.M.E. 29d. Date signed (Month, D. January 16, 2012)	∠ay, redij
	30. Name and address of person who completed cause of death (Item 23a)	
	Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
State Registra	3 P B 1 7 7 7 11 1 7 17 17 . AT CHINA ROW	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Januar Physician/ CANNOR JR 6 32M 4/Vanys Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** lumbia Howard 0 If Under If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday) Year **Funeral** Months Director 1 M 2 D F 1938 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a State Funeral Director atonsu: 11e 1 Yes 2 No 10g. Citizen of What Country? USA 12 Was Decedent I Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever Armed Porces? 1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during mostrof working life, DO NOT use retired) Bene 1 Elementary/Secondary (0-12) Be 17. Father's Name (First, Middle, Last) ပ onnor. aughter Method of Disposition Place of Disposition (Name.or 1 Naurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Nenal Disease Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death been signed by the a should be detached 1 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an In the mosphilar within 24 hours after death.

To the Euneral Director: After this certificate has to the Euneral Director: After this certificate has to the funeral director, page 2 s autopsy performed 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 30641 2012 22 maryland 2/22) oad Back RIVER MUCK

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Winfred T. Cannaday Jannan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Glen Burnie Anne Arundel Baltimore Washington Medical Cen. Birthplace (State or Foreign Country) Social Security Number If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthdav) If Under 1 Year **Funeral** (Month, Day, Year) 229 16 7117 **Director** 1 X M 2 🗆 F 87 01/19/1924 Virginia Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director ms 23a or 28a-f s must be notified 1 Yes 2 X No **Baltimore** Anne Arundel Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S. Funeral 512 Wood Street 21225 items 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, "natural", or iter edical Examiner Black White etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Yes 2 X No Specify. 3 X Widowed 4 Divorced WW II Completed Year or Dates. Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) item 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) 8th College (1-4 or 5+) Truck Driver Mountain Side Trucking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental ! J. MICES Talmadge Cannaday Lottie Akers 19a. Informant's Name/Relationship (Type, Print) Important: If item 27 is many injury or other traumonce. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7907 Red Globe Court Severn, Maryland 21144 Janet Clayton / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Glen Haven Mem. Park 01/20/2012 Glen Burnie, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. Baltimore, Maryland 21225 erome 4001 Ritchie Highway . Vart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on, ach line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause Enter Cause (Disease or injury Examine Due to (or as a consequence of) burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month detached signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been siy completely filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an perform 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1- 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Centifying Number Practitioner: To the best of my brown of both occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 death (Item 23a) (Type, Print) 30. Name and address of person who completed cause of 31. Dat filed (Month, Day, Year 22. Registrar's Signature

DHMH 17 Rev 06-2011

Registrar

Funeral

Director

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Baltimore, Maryland 21215-0036	permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra		20a. Method of Dis 1 X Burial 2	position	☐ Removal from State	20b. Pl	ace of Disp emetery, cre	matory or	other place)	1/27	Date 7/201	2 2
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092	cian: The law requires that the death certificate be executed with the attending physician and ector, page 2 should be detached for use as the burial-transit	edical Examiner	23a. Part 1. Enter shock, or hea Immediate Cause disease or condition resulting in death) Sequentially list or if any, leading to incause. Enter Under Cause (Disease or that initiated even resulting in death)	onditions, numerically injury is	b. Due to (or as d. Due to (or a) d. Due to (or as d. Due to (or a) d. Due to (or a) d. Due to (or a) d. Due	a conseque	ence of):			uch as cardia	ac or respirat	ory arrest
tal Records, P.O. Box 68760	e death certifie the attending thed for use at	Completed by Physician/Medical	IF FEMALE: 23b. Was deceden in the past 12 1 Yes 2 9 Unknown	months?	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal	I death 3	☐ Ectopic				
s, P.O.	res that th signed by d be detac	d by Ph	Part II. Other signi		s contributing to death		ulting in the	underlying	g cause given	in Part I.	23e	. Did toba
ord	v requi	olete	1.		AMT FAIL						24a	. Was an autopsy
Sec.	sician: The law r s certificate has b lirector, page 2 s	E O	1		LEEY AMN						_ 1 [perform Yes 2
al F	an: T rtifica stor, p	BeC	25. Was case refer	red to medical						of Death (Ch	neck only one	e)
	ysici is ce direc	일	examiner? 1 Yes 2	No	Hospital:	tient 2 🗆	ER/Outpati	ent 3 🗆 I	DOA Other:	4 Nursing	Home 5	Resider
on of	nding Ph ath. r: After th ne funeral	Certificate:	27. Manner of Dea 1 ☑ Natural 2 ☐ Accident	5 Pending Investiga		ury ay, Year)	28b. Time injury	of M	28c. Injury at work? 1 ☐ Ye	s 2 🗆 No	28d. Des	cribe hov
Division of V	To the Hospital or Attending Physis within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral directors.		3 ☐ Suicide 4 ☐ Homicide	,	ed 28e. Place of in building, e	tc. (Specify,	·)				City	ation (Stre or Town,
_	ne Hospit in 24 hour ne Funera pietely filk	Medical	(Chook	2 Madical Eve	Physician: To the best o aminer: On the basis of lurse Practitioner: To t	examination	and/or inve	estigation, i	n my opinion.	death occurre	ed at the time.	, date and
	To the Comi		29b. Signature and	11/	/E24				9c. License n NES – a			29

5 2012

For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Collins Physician/ Jane Martha Mary 02.58 PM SANUARY 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALLIMORE CHY SINAI HOSPITAL OF BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) O 2 1 3 Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 213-32-4463 75 36 MD 1 □ M 2 🛭 F Yrs. Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Yes 2 No g. Citizen of What Country? U.S.A. 14. Race - American Indian, Black, White, etc. Black Specify: 6b, Kind of Business/Industry State of Maryland iden Surname) City or Town, State, Zip Code) Ltimore, Md 21211 Oc. Location - City or Town, State Crownsville, Md imore, Md 21215 Approximate Interval Between Onset and Death DAY 23d. Date of delivery Month Day Year acco use contribute to the cause of death? 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No nce 6 Other (Specify) w injury occurred eet and Number or Rural Route Number, State) se(s) and manner as stated. place, and due to the cause(s) and manner stated cause(s) and manner as stated d. Date signed (Month, Day, Year) JANUAMY 22, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MBBS SINAL HOSPITAL OF BALTIMORE ASHUT MULTANI 31. Date filed (Month, Day, Year)

State Registrar racke

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 12:36AM January Edward Matthew Canavan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Towson 1038 Marleigh Circle If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth Social Security Number **Funeral** (Month, Day, Year) Days Hours Min. Month: 215-16-1023 Director 1 🗶 M 2 🗆 F 89 1922 Aug. 01, Maryland show 10c. City, Town or Location 10b. County 10a. State at Director 3a or 28a-f sl 1 🗌 Yes 2 🎗 No MD. Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 1038 Marleigh Circle 21204 USA must within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner 1 X Yes 2 □ No "natural", or ò 1 Never Married 2 X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates White 3 Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Machinery Quality Control Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) မ Thomas Martin Canavan Margaret Diesel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1038 Marleigh Circle Towson, MD. 21204 Catherine R. Canavan/ Wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place 1 Durial 2 X Cremation 3 Removal from State Hilltop Service Co. 1-30-12 Towson, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature ervice Ligansee uneral Ruck lowson Funeral Home, 1050 York Rd. Towson, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CANCER PANCREATE disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to (or as a consequence of,: if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exam death certificate be executed and I-trar Due to (or as a consequence of): resulting in death) Last burialattending physician I for use as the buria Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death Physician/ 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Yes 2 No g Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown STENOSIS Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 1 Yes 2 No has 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2° No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: iniury 1 Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 126637 1 134 $k_{O/}$ who completed cause of death (Item 23a) (Type, Print)

Registrar

State

30. Name and address of

31. Date filed (Month, Day, Year JAN 2 5 201

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32. Registrar Signatura

DR #311

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			For	State of M	aryland /		artment of H		Mental Hy	giene		01523
			State Registrar			Cer	tificate of <u>L</u>	Death		Reg. No.	ULZ	01222
	Physicia	n/	Decedent's Name (First, Middle	,					2. Date of De Month	Day	2012	3. Time of Death
	Medic	al .	DUDLEY	I			CATZEN	1 1 1 1 1	JANUA			10:10P ^M
	Examin	er	4a. Facility Name (if not institution				TOWSON	Location of Death			ounty of Death ALTIMOR	F
	Eumanal		GILCHRIST HOS 5. Social Security Number		e (In yrs. last b	irthdav)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir			
	Funeral Director		215-14-8036	1 🛛 M 2 🗆 F		Yrs.	Months Days	Hours Min.	09718	71922	Cour	place (State or Foreign htry) MD
	land show d at	<u> </u>	Usual Residence of Decedent 10a. State 10b. County	у	10c. City, To	wn or Loc	cation				1	10d. Inside City Limits
	aryla a-f s ified	Director	MD BAI	LTIMORE	LUTH	ERVII	LLE					1 ☐ Yes 2 🗓 No
	or 28	늅	10e. Street and Number	31 2110 112	_ Born		10f. Zip Code			10g. Citize	n of What Cou	ntry?
	with 23a ust b	Funeral	4 YEARLING WA	ΛY			21093					USA
	eath tems er mi	표	11, Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. V	Vas Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp	ecify Yes or No-	14	. Race - Americ	
9	fter d , or i amin	by	1 Never Married 2 X Ma	rried 1 X Yes 2	No		Yes 2 X No		7 1 110 00 1, 010 1,	Sr	Black, White,	
ğ	urs a tural' al Exa	ted	3 Widowed 4 Divorce	d Year or Dates.							WHI	
21215-0036	e filed within 72 hours after death with the Maryland tal Hygiene. ad other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at	Completed	(Specify only high	ent's Education nest grade completed)		(Give I	lent's Usual Occup kind of work done o O NOT use retired)	ation during most of wor	king	16b. Kind	l of Business In	dustry
7	ithin iene.	Sol	Elementary/Seconday (0-12)	College (1-4 or	5+)	me. D		-OWNER		BALT	IMORE B	OX COMPANY
D	ed Fig.	Be	17. Father's Name (First, Middle,					18. Mother's Nar	ne (First, Middle,			
Maryland	should be fill and Mental is marked aumatic ev	ပ္	BERTRAM H. CAT	CZEN				HORTEN	ISE		BOW	MAN
ary	should b and Mer is mark raumatic		19a. Informant's Name/Relations	ship (Type, Print)	11	9b. Mailir	ng Address (Street	and Number or Ru	ral Route Numbe	ər, City or To	wn, State, Zip	Code)
	nd2s alth a n 27 i er tra		LADONNA CATZI	EN/WIFE		4 7	YEARLING	WAY, LUI	HERVILL	E, MD	21093	
ore	of Her		20a. Method of Disposition 1 □ Burial 2 ※ Cremation	2 Domoval from State		of Dispo	sition (Name of natory or other plac	ce)	Date	20c. Loca	ation - City or T	own, State
Ĕ	Page ment ant: ury o		4 Donation 5 Other	(Specify)	CARRO	LL C	REMATION	INC 01/2	3/2012	HA	MPSTEAD	, MD
Baltimore,	permit. Page 1 and 2 should be f Department of Health and Menta Important. If item 27 is marked any injury or other traumatic e once.		21. Signature of Funeral Service	Licensee		22	. Name and Addre					
	TO = # 0		23a. Part 1. Enter the disease, of	ar complications that source	d the deeth Di	o not onto					SVILLE,	MD 21208 Approximate
			shock, or heart failure. List	only one cause on each lin	e.							Interval Between Onset and Death
- mag	h sician/ Medical	1 10	disease or condition resulting in death)	a. Due to (coo	a consequenc	e v	nyoci	and i Al	OUTA	2011	on	angs
-	Examiner	Н		Due to (H as	a consequenc	e 01).	1					V
		ner	Sequentially list conditions, in any, leading to infinediate cause. Enter Underlying	b. Cum to (or de	e cunsactuano	w off:						
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events									
	be executed sician and burial-transi		resulting in death) Last	Due to (or as	a consequenc	e of):		•				
09		dical		d	_				<u> </u>			
6876	death certificate ne attending phy ed for use as the	cian/Med	IF FEMALE:									
9 X	th cer tendi or use	ian/	23b. Was decedent pregnant in the past 12 months?		2 Fetal de		Ectopic pregnan	су		23	3d. Date of delivers of Month	very Day Year
å	g e	1.22	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant 9 ☐ Unknown	at time of deati	n 5∟	Other (specify)		~			,
P.O. Box	requires that the de been signed by the should be detached	/ Phys	Part II. Other significant condit	tions contributing to death	but not resultin	ıg in the ι	ınderlying cause gi	iven in Part I.	23e. Did	tobacco use	contribute to	the cause of death?
S, F	signe d be	d by	stroke,	Dement	lea,	00	ronar	1	1 🗷	Yes 2	No 3 Pro	obably 4 🗆 Unknown
ord	requ been shoul	Completed	Artery d	iseme					24a. Was	s an		opsy findings available
ec	e law e has ige 2	m d							perf	opsy ormed?	death?	ompletion of cause of
<u>د</u>	Physician: The law this certificate has al director, page 2	Be C	25. Was case referred to medica	al Till			26. P	lace of Death (Che		2 🗹 No	i ⊟ res	2 🗆 110
Vit ²	ysicia s cert direct	To B	examiner?	Hospital:	tient 2 🗆 ER/	Outpatie:	nt 3 DOA Oth	ner: 4 Nursing H	lome 5 🗆 Res	idence 6	Other (Specia	y Hospic
of	ig Ph ter thi neral		27. Manner of Death	28a. Date of inj (Month, Da		o. Time of injury			28d. Describe	how injury of	occurred	
on	eath. or: Af the fu	lica	2 Accident Investigation M 1 Yes 2 No									
Division of Vital Records,	er d	Certificate:		mined 28e. Place of In	jury - At home, tc. (Specify)	, farm, str	eet, factory, office			(Street and i wn, State)	Number or Run	al Route Number,
	5 분 분 드			- 1					1			
	pital or A burs after eral Direc filled in by	g	20g Cortifier 1 Toutiful	an Physician: To the best o	f my knowledg	e death	occured at the time	e date and place	and due to the o	ause(s) and	manner as stat	ted.
Ω	Hospital or 24 hours aft Funeral Dil leted filled in	ledical	Check 2 Medical	ng Physician: To the best of Examiner: On the basis of	examination and	d/or inves	tigation, in my opini	ion, death occurred	at the time, date	and place, a	and due to the c	ause(s) and manner state
Ω		Medical	Check 2 Medical	Examiner: On the basis of ng Nurse Practioner: To the	examination and	d/or inves	tigation, in my opini death occurred at the 29c. Licens	ion, death occurred ne time, date and pl	at the time, date	and place,	and due to the c and manner as signed (Month)	ause(s) and manner state stated.

State

Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Oi Physician/ 0547 AM EARLINE CHASE 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** University of MARY land MEDIZA! center Beltimore N/A If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Number - 5516 214-44 Hours Director 1 🗆 M 2 💢 07/06/1942 Maryland 69 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a, State Examiner must be notified at Director 1 Yes 2 No N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. items 23a 21230 2218 Annapolis Rd. death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. "natural", or 9 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify:Black 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Should be filed within 72 rand Mental Hygiene. entary/Secondary (0-12) College (1-4 or 5+) Machine Operator MD Cup 11th Grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Chase Robert Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other traus 2415 Annapolis Rd., Baltimore, MD 21230 Anita Partlow(daughter) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 🔀 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) King Mem. Park Cem01/27/12 Baltimore, MD 21. Signature of Funeral Service Licenses retrich 1 MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ GASTVOINTESTIMA disease or condition Medical resulting in death) Examiner 4 weeks quentially list conditio Section little conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical death certificate be Box 68760 IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ for in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 1 ☐ Yes 2 ¥ 9 ☐ Unknown g Unknown the P.O. I signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by albicans 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an • Hospital or Attending Physician: The law to 24 hours after death. • Funeral Director: After this certificate has to autopsy perform 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗶 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA upletely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 Pes 2 No Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 3 29b. Signature and title of ce 2012 27413 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar SCFER

DANA

DHMH 17 Rev 06-2011

32. Registrar's Signature

5245 W Running BROOK RD #202 COLUMBIA, MD 21044

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ Viola DuBose 5:30a Jan 21, 2012 Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Randallstown **Baltimore** Seasons Hospice of Baltimore Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. **Funeral** Months Days Hours 1 🗆 M 2 ื F **Director** 250-72-4899 95 SC Yrs Aug 6, 1916 Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State death with the Maryland Examiner must be notified at Director 1 XYes 2 No **Baltimore** MD **Baltimore City** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 23a Funeral 916 Pennsylvania Avenue 21201 U.S.A items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? 1 Yes 2 No Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 K No Specify If Yes Give Specify. Black 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) life DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) **Factory Worker Factory** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ellie Durant **Evelina Durant** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD 21239 Geraldine James 1605 Winford Road. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State Jan 28, 2012 Lansdowne, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion Cemetery Sign ture of Funeral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Futaw Place Baltimore, Md 21217 Nat caused the death. Do not enter the mode of Aling, such as caldiac or respiratory arrest, Approximate Interval Between neet and Death Part 1 Pinter the disease, or complications shock, or heart failure. List only one cause Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last signed by the attending physician d be detached for use as the buria Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE yes, outcome of pregnancy Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 4 ☐ Pregnant 9 ☐ Unknown Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Unknown Records, Completed been 24b. Were autopsy findings available Clernoxh ce cime 24a. Was an prior to completion of cause of death? after death. Director: After this certificate has filled in by the funeral director, page 2 performe 2 No 1 Yes 1 Yes 2/ 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Be 2 100 ပ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural injury 5 Pending 1 Tes 2 🗌 No 2 Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one

State Registrar Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 1:30 PMM January Susan Tardy Dews Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Forest Hills Nursing Home Forest Hill Howard 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, 1 M 2 XF 143-22-9443 Virginia 82 **Director** May Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Virginia Campbell Lynch Station 1 Yes 2X No 10e. Street and Number 5 10g. Citizen of What Country? ral", or items 23a or Examiner must be r Funeral 1233 Wileman Road 24571 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: "natural" 3 X Widowed 4 □ Divorced Black Completed Year or Dates of Health and Mental Hygiene.
item 27 is marked other than "natur
other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ should be Samuel Tardy, Sr. Mattie Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau Jerry Wadsworth (Son) 1233 Wileman Rd., Lynch Station, VA 24571 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Shilon Baptist Church Cemetery 1 X Burial 2 Cremation 3 Removal from State 4 Oonation 5 Other (Specify) 1/21/2012 Lynch Station, VA 22 Name and Address of Facility
METROPOLITAN FUNERAL SERVICE,
5517 VINE STREET, ALEXANDRIA, Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Enporage percon Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): attending physician and for use as the burial-transit B. that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been signated by page 2 should by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No **Division of Vital** To the Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner^e ٥ 1 🗋 Yes Other: 2 1 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death. To the Funeral Director: After this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated completed 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 035-5 Dav < Jan 50 15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12000

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Pay Year), 2012

32. Registrar's Signature

				Plea	se Type or State o			ndelible II artment of			-		_	ble.	
			For State Registrar			, maryia		tificate of				Reg. No		0 !	0 0150
in a	Physicia Medic		1. Decedent's Name Bettie	Maria	Delgad						2. Date of De Month Januar	D-	3 20	Year	-3. Timbof Death 3
	Examir	er	4a. Facility Name (if i				ore	4b. City, Town,	or Location		ciny	4c	. County o		
Ť	Funeral Director		5. Social Security Number 220 - 40 - 8697 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Months Days Hours Min. 05 / 23 / 05 / 23 / 05 05 / 23 / 05 05 / 23 / 05 05 / 23 / 05 05 / 23 / 05 05 / 23 / 05 05 / 23 / 05 05 / 23 / 05 05 / 23 / 05 05 / 23 / 05 05 / 23 / 05 05 / 23 / 05 05 / 23 / 05 05 / 23 / 05 05 / 23 / 05 05 / 23 / 05 05 / 23 / 05 / 23 / 05 05 / 23 / 05									ay, Year)	9. Birthplace (State or Foreign Country)		
	and show Lat	ō	Usual Residence of 10a. State	Decedent 10b. County		L	y, Town or Lo	cation							Od. Inside City Limits
	Maryla 28a-f	irect	MD	N/A			Bal	timore							1 X Yes 2 □ No
	with the 23a or st be r	Funeral Director	10e. Street and Number 10f. Zip Code 10g. Citizen of 2121 Windsor Garden Lane Apt238D 21207 U.S.									tizen of W		try?	
	death v		11. Marital Status		12. Was Dece	edent Ever in U.	S. 13. V	Vas Decedent of Yes, specify Cul	Hispanic Ori	igin? (Spe	cify Yes or No-		14. Race	- America	
936	s after al", or Examir	d by	1 Never Marrie 3 Widowed 4			2 □ χ o ⁄e	- 1	Yes 2 1			induity otoly			, White, e	
21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed		15. Decedent			16a. Deced	lent's Usual Occu	upation e durina mos	t of worki	na	16b. K	ind of Bus		
2121	within 7 giene.	Com	Elementary/Seconunk	ndary (0-12)	College (1	-4 or 5+)		O NOT use retired U rses				G	BMC		
	tal Hyg	To Be	17. Father's Name (F		,						e (First, Middle		Surname)		
Maryland	ould bond bond marke		William 19a. Informant's Nar			r.	10b Mailir	ng Address (Stree			Smith		Town St	ata Zin C	adal
	nd 2 sh ealth ai n 27 is ier trau	- 1			tzgeral	d(son)	4.0	-							
Baltimore,	permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trau	1	20a. Method of Dispo 1 ☐ Burial 2 ☑ 4 ☐ Donation	Cremation	3 Removal from	State	emetery, cren	sition (Name of natory or other pl		. /	Date 5 12		ocation - 0	•	
Saltii	permit. P Departm Importai any injui		21. Signature of Fun			101			-	-	-				PA MD21217
ш	<u>~</u> □ = # •		23a. Part 1. Enter th	e disease or o	omplications that	LECLAS.							timo	ore,	
-	'h, sician/		shock, or heart Immediate Cause (F disease or condition	failure. List on inal	ly one cause on ea	ch line.									Approximate Interval Between Onset and Death 2 CLUS
멸	Medical Examiner		resulting in death)	- 4	a. Due to	(or as a consequ	uence of):	respire	noug	0	urane				2 days
		ner	Sequentially list con if any, leading to imp	nediate 🌆	b. Due to	(or as a consequ	uence of):	lung	arei	L (h	isis			-	a anys.
	be executed sician and burial-transit	Examiner													
0		ह्य													
9289	rtificate ling phy e as th	/Med	IF FEMALE:												
Box 68760	Attending Physician: The law requires that the death certificate by ar death. ector. After this certificate has been signed by the attending physi by the funeral director, page 2 should be detached for use as the I	Physician/Medi	23b. Was decedent p in the past 12 m 1 ☐ Yes 2 ☐ 9 ☐ Unknown	Ectopic pregna Other (specify)	Ectopic pregnancy Other (specify)				23d. Date of delivery Month Day Year						
P.O.	that the dea ned by the a detached f		Part II. Other signific				9	nderlying cause (given in Part	l.	23e. Did t	tobacco u	use contrit	bute to the	e cause of death?
ds, l	requires th	ted b	itypestension Diabetes Mellitus type 2 24a. Was arranged autops								Yes 2	s 2 No 3 Probably 4 Unknown			
ecor	The law re ate has be page 2 sh	Completed by	Diabe	tes 1	Mellihi	s type	2 2				24a. Was		pr	ere autoprior to coneath?	sy findings available apletion of cause of
al R	ician: The certificate rector, pag		25. Was case referred	to medical	1			26.	Place of Dea	th (Check	1 🗌 Yes	2 V N	0 1	Yes	2 [] No
Vita	Physician: this certific ral director,	유	examiner? 1 Yes 2	No	Hospital:	Inpatient 2 🗆	ER/Outpatien	Lou	har	-	me 5 🗀 Resi	dence 6	Other	(Specify)	
on of	ttending P death. stor: After to y the funera	Certificate:									28d. Describe	how injur	y occurred	d	
Division of Vital Records,	e Hospital or Attend 24 hours after death • Funeral Director; A letely filled in by the f											Street and wn, State,		r or Rural i	Route Number,
	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical	(Check 2	Medical Ex	Physician: To the bas aminer: On the bas lurse Practitioner	is of examination	and/or invest	igation, in my opir	nion, death oc	curred at	the time, date a	and place	, and due	to the cau	se(s) and manner stated.
	To the I within 2 To the I completed		29b. Signature and ti		- MBB	ς			se number	``		29d. Date signed (Month, Day, Year)			-
		}	30. Name and addres				23a) (Type. P	rint)	5-000)		Jan	war	4,2	3,2012
			Rutika	Me	hta M	BBS	Sine	ai Ho	Spita	1 0	Bal	him	ore.		
	Stat	e	31. Date filed (Month,	Day, Year)	32. R	egistrar's Signat	ture								

DHMH 17 Rev 06-2011

State Registrar

State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Andrew L. Davis Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Good Samaritan N/A Baltimore 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** Hours Maryland h*2^MM*75^M7^M9739 216-34-4402 Director Usual Residence of Decedent or 28a-f shov notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 ¥ Yes 2 ☐ No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r items 23a or iner must be n Funeral 29th St. 123 W. 21218 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status or than "natural", or iter the Medical Examiner Black, White, etc. Armed Force ģ 1 Never Married 2 Married Yes 2 No 1 ☐ Yes 2x No Specify: If Yes Give 3 Widowed 4 Divorced Black Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. tant: If item 27 is marked other than ury or other traumatic event, the Melury or other traumatic event or other event or other traumatic event or other traumatic event or other event Elementary/Seconday (0-12) College (1-4 or 5+) unk American Red Cross vears Be Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, ဂ Andrew L. Davis Sr. Blanche Watkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1006 Wildwood Pkwy, Baltimore, Rodney Davis(son) MD 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or other 1 Burial 2 X Cremation 3 Removal from State on-site Crematory 01/24/12 4 Donation 5 Other (Specify) Baltimore, MD 21. Signature of Funeral Service License Joseph H. Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Intra crania disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine that the death certificate be executed and the burial-tran Due to (or as a consequence of): attending physician Physician/Medical 23b. Was decedent pregnant 23d Date of delivery in the past 12 months?

1 Yes 2 No Month 1 ☐ Yes ∠ L 9 ☐ Unknown the P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Cere brovariulas 2 No 3 Probably Unknown Records, 1 Tyes Completed hamalinidemia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 24 hours after death. Funeral Director: After this certificate 1 Yes 2 No or Attending Physician: Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Tes Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) the funeral 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: Natural 5 Pending 2 Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, filled in by determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 | Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D 69540 15 2412 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) worlNan Parkville MD 21234. - Wards Rd Swite 204 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Andrew

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 5,101,10g,15,20b-c, per fh,g923 1-25-12 sm State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Ejike Ezenezi Robins 2012 1:30a. 01 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Bethesda Health & Rehab. Center Bethesda 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
3 21 65 Funeral 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1**X** M 2 □ F Months Days Hours Min. 476-25-9772kn Nigeria **Director** 46 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 No DC NA Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Ukn -Ukn 23a Completed by Funeral 2300 Goodhope Road Apt 207 20020 USA/Nigeria 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Black, White, etc. 1 Never Married 2 Married "natura!", or Maryland 21215-0036 1 ☐ Yes 2 √ No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)kn Elementary/Seconday (0-12) Disabled Disabled permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygiei Important: If item 27 is marked other I any injury or other traumatic event, th 5th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Edna Ifeude Nzekwe Mark Ezenezi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 Tokay Ct., Randallstown, Md 21133 Gloria OnJeme-Cousin Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place). 20c. Location - City or Town, State Date Ukn 1 🕅 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Nibotown, Nigeria Baltimore, Md Compound 3/15/12 21. Signature of Fune at Service-Licens 22. Name and Address of Facility March F/H West 21215 4300 Wabash Ave, Baltimore, Md 23a. Part 1. Enter in shock Part 1. Enter In Sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he we allure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Mefastatic Osteosarcoma of mandit Physician/ disease or condition resulting in death) ien knowr Medical Due to (or as a consequence of): Examiner Sequentially list conditions, n any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year signed by the and be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death2 ģ anemia of cancer Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Weight 1055 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 this certificate 1 Yes 2 No ☐ Yes 25. Was case referred to Medical Be 26. Place of Death Check only one) examiner? Other: ٩ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending 1 Matural iniurv work? 1 ☐ Yes 2 ☐ No 5 Pending hours after death. neral Director: Aft illed in by the fur 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital of within 24 hours a To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number Chrowdy 1743121 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHOWD, HYRY, MD: 605 Main St, Laurei, MD 24747 32. Registra 's Sign ture State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Vear Physician/ Gid FM Charles Adam Fecher 16 2012 Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Baltimore Agnes Hos If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Days Hours Gountry) Maryland Director Nov 94 216-07-8033 Usual Residence of Decedent shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at with the Maryland Director 1 ☐ Yes 2 X No MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21227 3300 Benson Avenue #405 permit. Page 1 and 2 should be filed within 72 hours after death valepartment of Health and Mential Hygiene.
Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Completed by 1 Never Married 2 Married Yes Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 XWidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) executive archdiocese Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Elizabeth Hanna Adam Fecher 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8077 Croydon Way; Pasadena, MD 21122 Elizabeth Fecher - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Cher (Specify) 22. Name and Address of Facility State Anatomy Board Ronal c 655 W. Baltimore St; Baltimore, MD 21201 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or co Ph_sician/ EMPHYSEM Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Physician/Medical Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death. the attending physician and hed for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown **To the Funeral Director:** After this certificate has been signed by the atte completed filled in by the funeral director, page 2 should be detached for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ✓ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performed? Yes 2 1 Tyes 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: ၉ 1 Tyes 1 Anpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🔼 Natural 5 Pending 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) D61829

State Registrar CATON AVENUE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's S

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MABLE FRANCIS 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 6108 63rd PL RIVERDALE PRINCE GEORGE'S 5. Social Security Number 7. Age (In yrs. last birthdav) 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** JAMAICA Months Days Hours 11/16 Day 1 □ M 2 🖵 F 549-67-3178 1934 Director Usual Residence of Deceden ral", or items 23a or 28a-f shov Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1X Yes 2 □ No PRINCE GEORGE'S RIVERDALE 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 6108 63rd PL 20737 UNITED STATES Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Narried Completed by Yes 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: BLACK "natural", 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical Is 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) NURSING ASS NURSING 2Yrs Be 18. Mother's Name (First, Middle, N SARAH HIGGINS 7. Father's Name (First, Middle, Last)
PERCIVAL CORRODUS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19110 NEW HAMPSHIRE AVE BRINKLOW, MD 20862 PATRICIA BUDD/MOTHER 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 Cremation 3 Removal from State GEORGE WASH. CEM 1/29/2012 ADELPHI, MD 4 Donation 5 Other (Specify) 1425 MARYLAND AVE N.E 21. Sign vere e Funeral Service Los nsee 22. Name and Address of Facility CAPITOL 20002 MORTUARY WASHINGTON DC omplications that caused the death. Do n enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or shock, or heart failure. List of Approximate Interval Between Onset and Death y one cause on each line Immediate Cause (Final Ph sician/ EREBROVASCULAR ACCIDENT disease or condition Medical resulting in death) Examiner CARDIOVASCULAR HYPERTENSINE Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events physician and s the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Dav Year Pregnant at time of death 2 No 1 ☐ Yes 2 ☑ 9 ☐ Unknown 9 Unknown the is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DEFICIENCY TRITICNAL 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an after death.

Director: After this certificate has page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No 1 🗆 Yes 2 🔀 No or Attending Physician: 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital 2 🗷 No 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) ASSISTED Link ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d, Describe how injury occurred work? injury 1 X Natural 5 Pending 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital or within 24 hours af To the Funeral Di completed filled in 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d Date signed (Month, Day, Year) 2012 D20986 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9001 WOODYAR 31. Date filed (Month, Day, Year)

JAN 2 5 2012 State Registrar

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month ERT Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death SEASONS HOSPICE @ NORTHWEST HOSPITAL RANDALLSTOWN BALTIMORE 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min. (Month, Day, Year) Director 116-03-0186 1 X M 2 □ F 93 06/06/1918 28a-f show 10b. County 10a. State notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD BALTIMORE BALTIMORE 10e Street and Number ö 10f. Zip Code 10g. Citizen of What Country? items 23a or ner must be n Funeral 6825 CAMPFIELD ROAD, #10-M 21207 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces? Black, White, etc. 6 þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Specify: 3 Widowed 4 Divorced Completed WHITE Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) AUTO PARTS MANAGER AUTOMOBILE DEALERSHIP Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 1 and 2 should be file if Health and Mental H item 27 is marked of ည CHARLES FISHER ${ t TILLIE}$ HYMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 ANGELA FISHER / WIFE 6825 CAMPFIELD ROAD, #10-M, BALTIMORE, MD 21207 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State of t Date permit. Page 1 a Department of I Important; If its any injury or of cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MARYLAND VETERANS 01/23/2012 OWINGS MILLS, MD . Signature of Funeral Service Lie 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph_sician/ NOCC disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine Dus to (or as a consequence of) flary kaoli e to immedicause. Enter Underlying or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Pregnant at time of death 5 Other (specify) Yes 2 No ed by the a detached 9 Unknown 9 Unknown been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has page 2 autopsy performed? 2 N 1 Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: ည 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence Other Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation after deat Director: Sulcide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a

To the Funeral D

completely filled Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 30. Name and address of person who completed cause of death (Item 23a) (Type B) 1 6 6 8 V 1 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 543 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ MARGUERITE V. GOLDSMITH 4: 25 AM e17 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE CITY GOOD SAMARITAN HOSPITAL N/A 7. Age (In yrs. last birthdav) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 1 M 2 X F Months 2/22/1922 Director 89 marv1and 212-32-9959 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Examiner must be notified at Director PARKVILLE 1 Yes 2 No BALTIMORE MD 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? ò Funeral USA items 23a 21234 8621 OAK ROAD Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. ò ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: WHITE Specify: "natural", 3 X Widowed 4 Divorced Completed injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12TH GRADE College (1-4 or 5+) and Mental Hygiene. OWN HOME HOMEMAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ UNAVAILABLE ADELAID JOHN HESSION permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21234 BALTIMORE, MD FRANK GOLDSMITH/SON 8623 OAK ROAD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State METRO CREMATORY, INC. 1/23/2012 CATONSVILLE, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, 21286 8521 LOCH RAVEN BLVD. TOWSON, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Phylician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical certificate be Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No ō Year Month Day Pregnant at time of death ed by the a detached P.O. signed by Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No has page 2 certificate 1 Yes 2 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) 1 🗌 Yes ည 1 X npatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 \square Pending Accident work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: Air completed filled in by the fu Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🔲 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day. Year)

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Registrar

DHMH 17 Rev 7/2009

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) **JAN 2** 5 2012 7000930

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Jan 15. 2012 7:15p M Marion Garrett Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A **Baltimore Keswick Multi-Care Center** 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 X F Days nth, Day, Year) Dec 13, 1929 MD 82 217-24-2363 **Director** Usual Residence of Decedent 28a-f shov aţ 10a. State 10b. Count death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No Examiner must be notified **Baltímore** MD **Baltimore City** ŏ 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 21215 U.S.A. 4109 West Rogers Avenue 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. ō þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 H No Specify. Black If Yes, Give Year or Dates Specify: "natural", Completed 3 X Widowed 4 Divorced Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. d other than " life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) **Baltimore City School** the **Principal** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental Fisher is marked o ည permit. Page 1 and 2 should be Department of Health and Menta Important. If item 27 is marked any injury over 1 pe Annie Ames William Ames 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4109 West Rogers Avenue Baltimore, MD 21215 Pamela Carter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 💢 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Owings Mills, Md. Jan 24, 2012 **Garrison Forest Veterans** ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Estep Brothers Funeral Service, P. A.
1300 Eutaw Place Baltimore, Md 21217 uneral Service Lio Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on gach line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician. multinFarct ementia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Due to or as a consuluence of cause. Enter Underlying Examin Cause (Disease or linjury that initiated events resulting in death) Last and the burial-tran Due to (or as a consequence of physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be in 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physicis P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death signed by the at Id be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ⋧ VASCULAR Division of Vital Records, ACCUPENT 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy page 2 2× No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural injury work? 1 ☐ Yes 2 ☐ No Accident Investigation filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 3 only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) wille DBCIUZ on who completed cause of death (Item 23a) (Type, Print) NOVIN CHANLES Street m.n 901 Registrar's Signature

Registrar

Box 68760 P.0. Division of Vital Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

Baltimore, Maryland 21215-0036

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	resulting in death)	Due to (or as a consequence of):										
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	that initiated events resulting in death) Last	Due to (or as a consequence of):										
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ted by Pl	· ·	ntributing to death but not resulting in the unary Artery Disease;		23e. Did tobacco use contribute 1								
Somple	Status Post Cerebr	rovascular Accident;	Dementia	autopsy prior to performed? performed?	autopsy findings available o completion of cause of ? 'es 2 \to No							
Be (25. Was case referred to medical	26. Place of Death (Check only one)										
인 B	examiner? 1 Yes 2 No	lospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ★Residence 6 ☐ Other (Specify)										
	27. Manner of Death 1 ★Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of injury 28b. Time of injury injury	28c. Injury at work? M 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred								
Certif	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, streed building, etc. (Specify)	et, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
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_	29b. Signature and title of certifier	An.	29c. License number	29d. Date signed (Mor	Date signed (Month, Day, Year)							
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D22549

Suite 2600, Riverdale, MD 20737

January 23, 2012

State Registrar

6510 Kenilworth Ave.,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

G.M. Din, MD,

JAN 2 5 2012

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND ITEM#8 per FH, G923, 1/25/2012, WS
State of Manyland / Department of Health and Mental Hygiene

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-			GILCHRIST CENTER 5. Social Security Number 6. S				COLUMB If Under 1 Year		A Hre	8. Date of Birth	HOW		alass (Ctata au Favoian		
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Baltimore,	t. Page tment o tant; if ijury or		4 Donation 5 Other (Speci	ify)	N N	EMORIA	natory or other place VID L. GARDEN	$\mathbf{S} \mid \mathbf{C}$		3/2012			JRCH, VA		
Bal	permit. Page 1 and Department of Hea Important: If item any injury or other once,		21. Signature of neral ervice Licen	Me		22	Name and Addre						INC. MD 21208		
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between				
	hysician/	M 3	Immediate Cause (Final disease or condition	. der	MHC							6	Onset in Death		
-	Medical Examiner		resulting in death)	Due to (or as a cons	uence of):									
		Jer	Sequentially list conditions,	b. Due to (oraela conecqu	rence of;						- 10			
	nted d ansit	Examiner	cause. Disease or injury that initiated events	,		,									
	execu an an rial-tr	i Ex	resulting in death) Last	Due to (or as a consequ	uence of):									
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Box (ath ce attend for us	cian	23b. Was decedent pregnant in the past 12 months?			aldeath 3 🗌	Ectopic pregnand Other (specify)	СУ				ate of deliventh	delivery Day Year		
œ.	hat the death certifined by the attending detached for use a	ysi	1	g 🗌 Unkn		Jedin 0 L	- Carici (speciny)								
P.0	The law requires that the death certi ate has been signed by the attendin page 2 should be detached for use	by P	Part II. Other significant conditions	contributing to de	ath but not res	ulting in the u	nderlying cause gi	ven in Part I.		23e. Did tob	acco use cont	tribute to t	the cause of death?		
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Records,	has been ye 2 shoul	Completed								24a. Was ar autops		Were auto	opsy findings available ompletion of cause of		
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tal	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			26. P	ace of Death	n (Check	only one)			1/250		
of Vital	Phys this ral di	2:	1 L Yes 2 No 27. Manner of Death	1 28a. Date of	Inpatient 2 of injury	ER/Outpatien 28b. Time of	t 3 DOA 28c. Injur	4 ∟ Nur		ne 5 Reside			MADURE		
n c	Attending F r death. ector; After by the funer	Certificate:	Natural 5 Pending 2 Accident Investigatio	- 1	h, Day, Year)	injury	work		- [od, Dosonibo no	w injury coourt				
Volume 1								2	28f. Location (Str		er or Rura	al Route Number,			
<u>S</u>	Hospital or 24 hours afte Funeral Dire stely filled in			Dandii	ig, etc. (opcon)					Gity Of TOWIT	, State)				
	To the Hospital or Attend within 24 hours after death To the Funeral Director, a completely filled in by the	Medical		iner: On the basi	s of examinatio	n and/or invest	igation, in my opini	on, death occ	curred at	the time, date an	d place, and du	ie to the ca	ause(s) and manner stated.		
	To the within 2 To the соттрle	Σ	only one) 3 Certifying Nur 29b. Signature and title of certifier	se Practitioner:	to the pest of r	ny knowleage,	29c. Licens		e and plac		9d. Date signe				
			Mondon 5	00000	100	10	RIC	525	10		Daire	Z ex	22,2012		
	'		30. Name and address of person who	completed cause	e of death (Item	23a) (Type, P	rint)		(C)	,		7			
_			Kelpece Jus	rela (03510	Cedo	r lan	2 C	011	alle	M	2x	XX		
	Stat Registra		31. Date filed (Month, Day, Year)	32. Re	egistrar's Signa	ture									

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Hanson M 805:51 WENTID 14 2012 January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard 9516 Baltimore National Pike Ellicott City Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days Hours Min (Month, Day, Year) 11y 17, 1951 July Missouri Director 1 👿 M 2 🗆 F 217-54-4526 60 ms 23a or 28a-f show must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 72 hours after death with the Maryland Director 1 Yes 2 X No Ellicott City MD Howard 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? items 23a Funeral USA 9516 Baltimore National Pike 21042 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or iter Black, White, etc. , or 1 Never Married 2 Married ρ Baltimore, Maryland 21215-0036 black 1 ☐ Yes 2 X No Specify: 3 🗌 Widowed 4 🗆 Divorced Completed Year or Dates ed other than "nature event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Department of Health and Mental Hygien Important: If item 27 is marked other th any injury or other traumatic once. 12 executive sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Pauline Norman Floyd Alexander Hanson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norma Hanson - wife Baltimore National Pike; Ellicott City, MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility State Anatomy Board Ronal Director 655 W. Baltimore St; Baltimore, MD 21201 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ rostate disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause E tor underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 2 No the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page death? 1 Yes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 🗌 Yes 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) the funeral dir 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No s after death. I Director: After t Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural injury 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral C

completely filled To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifiel Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Chec Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 142012 0053337 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Smith 31. Date filed (Month, Da), Year)

IAN 2 5 2012 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ³2^{Time} of Death Physician/ JANUARY 21, 2012 Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** TOWSON BALTIMORE SAINT JOSEPH MEDICAL CENTER 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** Hours 241-08-5273 Months **Director** 1 2 M 2 □ F APR. 10, 1954 57 28a-f show 10d. Inside City Limits 10c. City. Town or Location notified at **Funeral Director** 1 Yes 2 No MD BAlto 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Ю must be items 23a EDMONDSON AVE 21216 Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian the Medical Examiner Armed Forces? Black, White, etc. ō by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Black "natural", 3 ₩idowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. Do NOT use retired) (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) SECURIT Officer Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ WILLIAM SANDers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cpdg, 19a. Informant's Name/Relationship (Type, Print) of Health item 27 7 HATE BELL MARMIN BroTHer 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1
Department of
Important: If it
any injury or o 1 Burial 2 S Cremation 3 Removal from State 1-25-12 CATOMSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) Crematery MeTro ure of Funeral Service Licensee 23a. Part 1. Enter the disease, occomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death) CARDIAC FAILURE/ARRHYTHMIA YEARS ath Physician/ Medical Due to (or as a consequence of) YEARS Examiner ATHEROSCLEROTIC CORONARY ARTERY DISEASE Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) 1 Yes 2 No 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by CHRONIC HYPERTENSION 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 24 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2**X** No မ 1 🗌 Yes 1X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work?
1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after deatl Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier 🛚 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D38655 ddress of person who completed cause of death (Item 23a) (Type, Print) RC STEWART FINNEY M.D., 7601 OSLER DRIVE TOWSON, MD 21204 Character 82 Register's S State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death Decedent's Name (First Middle | ast) 2. Date of Death 3. Time of Death Physician/ January 2012 10:55 P M Robert Bruce Johnstone Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Sunrise Assisted Living 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Days Months Hours Min. 577-24-2151 Director 1 X M 2 □ F 89 March 3, 1922 Washington DC Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director notified 1 Yes 2X No MD Frederick 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 21703 5632 Ashburn Terrace USA items 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No 194
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. r than "natural", or the Medical Examin þ 2 No 1941-1 Never Married 2 X Married 3altimore, Maryland 21215-0036 1 Yes 2 No Specify white 3 Widowed 4 Divorced Completed 1945 Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 0 photo analysis event, th photography Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental Fis marked o : If item 27 is marked or other traumatic ev မှ George D. Johnstone Gladys E. Remson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health Alice Thompson - daughter 9011 Chesley Knoll; Gaithersburg, MD 20879 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from Department of Important: If any injury or once. Donation 5 Other (Specify) 22. Name and Address of Facility State Anatomy Board 21. Signat ector 655 W. Baltimore St; Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death shock or heart failure. List only one cause on each line Immediate Cause (Final Ph_sician/ ATHERN SCLENOSIS AUTEN - O NOVANY disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of, requires that the death certificate be executed and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the attending IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ been signed by the atte should be detached for Year Month Day Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate P 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: ရု 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury work?
1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signati 29d. Date signed (Month, Day, Year) W 01-12-2012 4795 SIBTE A KAZMI, MD 814 TO II HOUSE AVE MEDERICK 21701 MO

State

Registrar

31. Date filed (Month, Day, Year JAN 25

2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		For State Registrar	State of Maryla		icate of L		wientai n		012 0	155
Physicia Medic		1. Decedent's Name (First, Middle, La	Resa		es-Har		2. Date of I		Year	e of Death
Examin	er	4a. Facility Name (if not institution, give Manor Care Nur	sing Home		Balti			4c. Count	y of Death	
Funeral Director		5. Social Security Number 217-40-9834 Usual Residence of Decedent	7. Age (In yrs.		Under 1 Year onths Days	If Under 24 Hrs. Hours Min.		Birth Day, Year) L8 44	9. Birthplace (Sta Country)	te or Forei
aryland a-f shov fied at	Funeral Director	10a. State 10b. County MD NA	10c. C	ity, Town or Location					10d. Inside	e City Lim
n or 28	Dire	10e. Street and Number			Of. Zip Code			10g. Citizen of		
ns 23a must l	nera	2500 West Bely				1215		*	S.A.	
Department of Health and Mental Hygiene. Important: fi tiem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Married 2 🌠 Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give Year or Dates.		Decedent of His, specify Cuba Yes 2 X No	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No o Rican, etc.)	0- 14. Rad Bla Specify	ce - American Indian ck, White, etc.	
ene. • than "natu he Medical	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind life. DO N	OT use retired)	uring most of wor	king		Business/Industry	
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Menta narked natic e	은	William Jukes				Lueber	tha Ma	nning		
Ith and 27 is n traum	1	19a. Informant's Name/Relationship (7	• • • • • • • • • • • • • • • • • • • •					ber, City or Town, : Baltin	State, Zip Code) nore, Md	21
of Heal		20a. Method of Disposition	20b.	Place of Disposition cemetery, cremator	n (Name of	!	Date		- City or Town, State	
tment tant: Il jury or		1 Burial 2 Cremation 3 4 Donation 5 Other (Speci	fy) j C	n-Site	ry or other place		0/2012	Baltin	more, Md	
Depart Impor any in		20. Signature Funeral Service Licent	. Sman	430	O Waba		Balt	imore,	Md 2121	5
ate has been signed by the attending physician and hadical page 2 should be detached for use as the burial-transit	edical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect Due to (or a conse	quence of):	len i	veci di	mt			
been signed by the attending physician and should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregn 1 Live Birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3 🗌 Ec	topic pregnancy her (specify)	у			ate of delivery onth Day	Year
i signed by Id be detac	þ	Part II. Other significant conditions c	ontributing to death but not re	sulting in the unde	lying cause give	en in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknow			
ate has page 2	Completed		opsy formed?	24b. Were autopsy findings availat prior to completion of cause death?						
certificate lirector, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	3======================================	TOthe	ce of Death (Chec				520
r: After this re funeral c	Certificate: To	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	1 ☐ Inpatient 2 ☐ 28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work	at	Wursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred □ □ No			
_ 0		3 Suicide 6 Could not b	building, etc. (Special	fy)			City or To	own, State)	er or Rural Route Nu	mber,
the Fune the Fune mpletely fi	Medical	(Check 2 Medical Examination only one) 3 Certifying Nurse	sician: To the best of my know iner: On the basis of examination se Practitioner: To the best of	on and/or investigati	on, in my opinion th occurred at th	n, death occurred a ne time, date and pl	at the time, date	e and place, and du the cause(s) and r	e to the cause(s) and manner as stated.	manner:
100		29b. Signature and title of certifier	Janson	mp	29c. License	71464		1	d (Month, Day, Year)	
7		30. Name and address of person who of	completed cause of death (Iter			W Sinte	308.	BALTI	more mi) 21

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND #26 TER PHY G923 1/30/2012 JH
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 20ÎZ January Margaret Jackson 2:30 Рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Queen Anne 2010 Starr Road Queen Anne If Under 1 Year If Under 24 Hrs.

Months Davs Hours Min. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Nov 30, 1937 Maryland **Director** 215-36-0256 1 M 2 X F 74 Usual Residence of Decedent 28a-f show 10a State 10b County 10c. City, Town or Location notified at Director 10d. Inside City Limits 1 Tes 2 X No MD Queen Anne Queen Anne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral USA 2010 Starr Road items be filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No Black, White, etc. ò þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 K No Specify: "natural", 3 XWidowed 4 Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the 12 0 bookkeeper bookkeeping event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ျှ permit. Page 1 and 2 should be Department of Health and Men Important; If item 27 is marke any injury or other traumatic C.A. Stanley Howeth Clara Virginia Covington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol J. O'Donnell - daughter PO Box 359; Queen Anne, MD 21657 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1

Burial 2

Cremation 3

Removal from State 4 X Donation 5 Other (Specify) 22. Name and Address of Facility State Anatomy Foard Ronald Director 655 W. Baltimore St; Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Ph si i n disease or condition resulting in death) Month Medical Due to (or as a con equence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events Due to (or as a consequence of): Exami trar resulting in death) Last Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month the a Pregnant at time of death Day Year 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by vtery Division of Vital Records, plnous Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy performe 2 No Yes 2 No 1 Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🗷 No Other: 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home XX Residence After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending iniurv Accident
Suicide hours after death neral Director: A filled in by the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) ess of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addi 105 509 d 31. Date filed (Month, Day, Registrar's Signa parke State 5 2012 2 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19a Per FH G925 3/06/2012 JH State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ EVELYN E. JAMES 8:45 P.M JANUARY 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE TIMONIUM STELLA MARIS HOSPICE Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** Months Days Hours **Director** 1 M 2 XF 220-18-6065 6/13/1926 MARYLAND 85 28a-f show 10d. Inside City Limits "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2X No MD TIMONIUM BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21093 USA 2525 POT SPRING ROAD 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 8:45 р.т. 21215-0036 1 Yes 2 No Specify Specify: WHITE 3 XWidowed 4 Divorced Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) CALVERT HALL HIGH d Mental Hygiene. marked other than ' College (1-4 or 5+) Elementary/Secondary (0-12) SCHOOL CAFETERIA WORKER 12TH GRADE Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2012 ပ PAULINE KILCHENSTEIN JOHN E. DOYLE 19a. Informant's Name/Belationship (Type, Print)
DOYLE
JOSEPH DAYLE/BROTHER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22. GLENELG, MD 21737 mportant; If item 27 14233 DAY FARM RD. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date **IANUARY** Page 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MEADOWRIDGE MEM. 1/28/2012 ELKRIDGE, MD PARK 4 Donation 5 Other (Specify MO1139 21. Signatur of Funeral Service 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, any 8521 LOCH RAVEN BLVD. TOWSON, MD no In Part 1. Enter the disease, or comprications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ COLON CANCER disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical P.O. Box 68760 as the attending IF FEMALE: for use a 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) 2 **X** No 1 | Yes 2 | 9 | Unknowr should be detached EVELYN JAMES Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe page 2 To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate to 1 Yes 2 No Division of Vital filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Yes Other: 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: (Month, Day, Year) X Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \square Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature ar 2017 30. Name and addre of person who completed cause of death (Item 23a) (Type, Print) JONES, CRNP 2300 DULANEY VALLEY RD. JACKIE TIMONIUM, MD 21093

DHMH 17 Rev 06-2011

State Registrar JAN Z U ZUIZ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TITEM#4a, perME, #10e, perFH, G924, 27672012, WS

State of Maryland / Department of Health and Mental Hygiene For State Registrar 01553 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month O I 21^{Day} 2012 11:30a M Medical Frank T. Johnson Jr 4a. Facility Name (if not institution, give street and number)
Rolling
3924 Rolland Road Unit Examiner 4b. City, Town, or Location of Death 4c. County of Death 9 Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) 1**火**□ M 2 □ F Months Days Hours Min. Country) 218-56-2231 **Director** 61 50 Usual Residence of Decedent "natural", or items 23a or 28a-f shov permit. Page 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c. City. Town or Location **Funeral Director** 10d. Inside City Limits MD NA Baltimore 1 X Yes 2 □ No 10e. Street and Number Rolling 3924 Roland Road Unit 10f. Zip Code 10g. Citizen of What Country? 21244 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 - Widowed 4 X Divorced Specify: Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade Ship Yard Laborer na Sparrow Point Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Frank Johnson Sr. Doris Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21216 19a. Informant's Name/Relationship (Type, Print) Ashlee Johnson-Daughter 2402 Calverton Heights Ave, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral 1/28/2012 Baltimore, Md Signatur of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Av Ave, Baltimore, Md 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ Artonic Sclen

Due to (or as a consequence of): disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner Due to for as a consequence of,: If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last physician a Completed by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 been signed by the attending p should be detached for use as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Dav Year 1 ☐ Yes ∠ ☐ Unknown g Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has t lirector, page 2 s autopsy performed? Yes 2 N death? Yes 1 Yes 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? 1 XYes Certificate: To 2 🗆 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) this in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c, Injury at 28d. Describe how injury occurred X-Natural injury 5 Pending work? 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours af

To the Funeral Di

completed filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 23,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TLutherville wimbl 31. Date filed (Month, Day, 32. State Registrar 9

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21/2012

Johnson 01

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Ma Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Louthy 7 Age (In yrs. last birthday) If Unde 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** If Under 24 Hrs. Months Min 19-10-9 1 🗆 M 2 📝 F Director Usual Residence of Decedent û show 10a. State notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 Ves 2 No ma 10e. Street and Number rms 23a or ò 10g. Citizen of What Country? Funeral permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygene. Important if item 27 is marked Artanay injury or Artanay. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced Specify 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working DO NOT use retired) econdary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ 0 ah en 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 🔏 🙊 🖊 🕏 (Brother) 19a. Informant's Name/Relationship (Type, Print) 9 20a. Method of Disposition 20b. Place of Disposition (Name of c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signatu Hone, P. A. 20 C MD 21210 nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, r heart failure. List only one cause on each line. 23a. Part 1 Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to as a consequence of) Examiner nonnev Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Lisease or Injur that initiated events resulting in death) Last burial-tran and Due to (or as a consequence of): attending physician d for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 X No 5 Other (specify) Month Dav Year Pregnant at time of death signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed this certificate 2 🗌 No 1 ☐ Yes 2 🗘 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Tes 2 No ၉ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 7. Manner of Death Certificate: 28c. Injury at work? 1 ☐ Yes 28b. Time of After Natural 5 Pending 2 🗌 No Accident Investigation within 24 hours after death

To the Funeral Director: /
completely filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Jannery

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

filed (Month, Day, Year)
JAN 2 5 2012

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32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** F. Kreamer Irma 2012 12:50 a M January /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Manor Care Ruxton Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 👿 F Days 139-14-1135 Director 89 March 30, 1922 New Jersey Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits ir than "natural", or items 23a or 28a-f shov the Medical Examiner must be redthed at Director MD. Baltimore Phoenix 1 ☐ Yes 2 🕱 No 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 14 Lochwynd Court 21131 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner musts once. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Completed by 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Legal Secretary 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Giuseppe Guiani Nicoletti Maria 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Kreamer/ Son Phoenix, MD. 21131 7 Lochwynd Ct 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 1-28-12 Cedar Lawn Cemetery Paterson, NJ 4 □ Donation 5 Other (Specify) 21. Signature of Fur ral Service Licenses 22. Name RVCK**Towson Funeral Home, Inc 1050 York Rd. Towson, MD. 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Aspiration **Physician** Treumon a /Medical Due to (or as a consequence of): Examiner Sub duras homatema Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit Due to (or as a consequence of): the attending physician ned for use as the buria P.O. Box 68760 Hyperti Midemi Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🐪 No Month Year 4 ☐ Pregnant at time of death Day 5 Other (specify) 9 I Inknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 42 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy this certificate perform 1 ☐ Yes 2/XINo 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 42 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2⊠No ٩ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only

State

30

Registrar DHMH 17 Rev 1/2001 29b. Signature and title of pertifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAYAM FIR PARA MO 7505 05

7505

32. Registrar's Sigrature

Osler Drive, Towson

29d. Date signed (Month, Day, Year) 01-23-12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

kila Kenan		State of Maryland / Department of Health	and Mental Hyg	giene	0010 0155
		Registrar Certificate of Death		Reg. No.	2012 0155
Physical Exan				Date of Death Month Day	3. Time of Death
		1 Clan	n, or Location of Death	Month Day January 21, 2012	
		3817 Edmondson Avenue Baltimo		40.	County of Death
Funera		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1	Year If Under 24Hrs.	8. Date of Birth(MM/D	D/YYYYY 9. Birthplace (State or
Directo	r	220-86-056 1 M 2 F 44 Yrs. Months	Days Hours Min.	4/19/196	Foreign Country)
	1	Usual Residence of Decedent		711111116	1 VIC.
W any		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
Maryland 28a-f show	þ	MD NIA Baitin	1016		1 Yes 2 No
h the Maryland 3a nr 28a-f sh	Director	10e. Street and Number	de	10g. Citize	n of What Country?
ith th	l is		21229		USA
eath w	Funerai	11. Marītal Status 12. Was Decedent Ever in U.S. 13. Was Decedent C 14. Was Decedent C 15. Was Decedent C 16. Yes, specify C	f Hispanic Origin? (Speci uban, Mexican, Puerto Ric	ify Yes or No- 14 can, etc.)	Race - American Indian, 8lack, White, etc.
fter d			No specify:	9.	pecify: Plank
ours a	A p		upation (Give kind of work	k done 16b, Kin	nd of Business/Industry
11215-0036 lid be filed within 72 hours dental Hygiene, awked other than "natus event, the Medical Exam	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	life. DO NOT use retired)		
5-0036 led within 7 Hygiene, other than	E	17 Embers New Clay Mills Land	caper	Pr	vate Companies
Filed at Hyg	Bec		18.Molher's Name (Fi	rst, Middle, Maiden Su	ırname)
ID 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a ur 28a-fah antic event, the Medical Examiner men be a citing at one	10		treet and Number or Rura	NCUY	or Town, State, Zip Code)
T 0 - 0 T	-	Mrs. Renes Kenan 14511 Ha	a oshir H	ALL DAL IL	or rown, state, zip code, 20172
ore, N s 1 and 2 of Health If item 2	01	20a. Method of Disposition 20b. Place of Disposition (Name of	certetery, Da	ate 20c. Lo	allon - City or Town, State
Pages rent of rathe		1 VBunal 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify:	Park 1/28	12012 W	andla na
Baltimore permit. Pages 1 a Department of He Important: If its injury or nther t	Ш	21. Sig vu of Funeral Service Licensee 22 Name and Add	rest of Facility	Juneral	Home, P. A.
		1 July Stein Teaus 10501 in	Nincth	Au Ba	1th 1110 21211
Physician /Medical		23a. P. 1. Enter the disease, or complication that caused the death. Do not enter the mode of dy fillure. List only one cause on each line.	ng, such as cardiac or res	spiratory arrest, shock	, or heart Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)			Death
		bue to (or as a consequence or).			
	Je I	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	<u> </u>		
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):			
executed an and al - transit					
e exe cian a rial -	edicai	X UNPENDED AMENDED 23a,27,28a-f per ME g923 1	/27/10 mpm		
760 cate b			/2//12 TRT	23d. D	Date of delivery
Box 68766 the death certificate the attending phy hed for use as the b	Physician/M	Live birth 1	3 Ectopic pregnancy		onth Day Year
BOX death	ysic	1 Yes 2 No 9 Unknown 9 Unknown 5 Other (Specify)			
P.O. Is that the gned by the detached			e given in Part I.	23e. Did tobacco use	contribute to the cause of death?
ires that signed be deta	d by			1Yes 2 ✓ N	o 3 Probably 4 Unknown
v requision should	Completed				24b. Were autopsy findings available
Che lay ate ha	E		-	autopsy performed?	prior to completion of cause of death?
Vital Records, ysician: The law requires to this certificate has been idirector, page 2 should	BeC		ice of Death (Check only		1 Yes 2 No
5 € £ €	10	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	Other Nursing Ho	me 5 Residence	6 V Other: Scene
n of ding Ph.		1 Notice (Month, Day, Year)	77	. Describe how injury o	оссилеа
SiO	Certification:	Accident Investigation Fd 1/21/12 Fd 8:15 am	1100 2 110	ınk ————	
Saffer ed in t	E	3 Suicide 6 Could not be determined (Specify) found at residence	building, etc. 28f.	Location (Street and I or Town, State) 38	Number or Rural Route Number, City 17 Edmondson Ave
Inspit four four funers		Tomicide Thomas		altimore, i	MD
Divisior Thathe Haspital ar Attend within 24 hours after death To the Funeral Director: completely filled in by the it	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opin	date and place, and due to on, death occurred at the	to the cause(s) and m time, date and place.	anner as stated, and due to the cause(s)
Ta wit	₩.	and manner stated.	nse number		e signed (Month, Day, Year)
		// // 0.0	C.M.E.		y 22, 2012
4	1	30. Name and addres of person who completed cause of death (Item 23a)			
OGNIE		Mary G. Ripple MD. Deputy Chief Medical Examiner 900 W. Baltimo	re Street, Baltimore	e, MD 21223	
St	ate	31. Date filed (Month 2014), 1901 2 32. Registrar's Signature			

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death -Month **Physician** Kalm David anuaci /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, 5. Social Security Number 9. Birthplace (State or Foreign Country)

MATY/AND 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) **Funeral** 216-50-0468 61 Director Usual Residence of Decedent the Maryland 10a. State 28a-f show 10b. Count 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Director notified BAltimore MARYLAND 10e, Street and Number 10f. Zip-Code 10g. Citizen of What Country? with ö ral", or Items 23a o Examiner must be 21224 400 HORNEL Funeral U.S.A. death y 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
unt: If Item 27 is marked other than "natural", or Ite Black, White, etc. ō 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No þ 3 Widowed 4 Divorced Whate Completed Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done a life. DO NOT use retired) during most of working Elementary/Secondary (0-12) College (1-4 or 5+) SEA MAN the Merchant Merchant MATINES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ဂ ORIS 6491e 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, ip Code) Rο DRIVE Department of Healt Important: If Item 2: any Injury or other i Injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation Middle River H 4014 -26- ZOIZ 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Joseph N 23a. Part 1. Enter the diseas shock, or hear failure disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, allure, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ASCVO long standing / /Medical Due to (or as a consequence of): Examiner CO long standing Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last ner Due to (or as a consequence of) sician and burial-transit Due to (or as a consequence of) attending physician d for use as the buris Box 68760 Physician/Medical The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death page 2 should be detached for I 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 🗌 Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown Completed peen 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? certificate has 1 🗌 Yes 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ► ER/Outpatient 3 ☐ DOA 2 No Other: 1 Yes မှ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after deau..

To the Funeral Director; After this of annietely filled in by the funeral d 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred or Attending 1 Natural 2 Accident 5 Pending investigation Injury 1 TYes 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide the Hospital 29a. Certifier (check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D-0061115 Mus January 22, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hardin Partle, No 4940 Eastern Avenue, Baltimore, MD, 21224 31. Dat State

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Funeral Director	١.	002-16-72		Sex 1 X M 2 □ F	7. Age (In yrs. 87	last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birtle (Month, Day Feb 8,		9. Birthi Coun Mai	lace (State or a try) .ne	Foreign	
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tnd 2 s lealth im 27				ere - wif			630 Glen	Arm Rd;	Glen Arm					
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Dispositi	remation 3				osition <i>(Nam</i> e of matory or other plac	ce)	Date	20c. Locati	ion - City or To	wn, State		
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		23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, heart failure. List only one cause on each line.												
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 🔲 🛚	Medical Exa	miner: On the basis	of examination	on and/or inve	stigation, in my opinion death occurred at the	on, death occurred a	at the time, date ar	nd place, and	d due to the cau	ise(s) and man	ner stated.	
To th To th		29b. Signature and title		70 / 1	MM)	29c. License	e number		29d Date sig	aned (Month, I	Day Year)		
·		· /WM	r. X		/		950	1433		jan (16, 20	12		
		30. Name and address of	of person wh	o completed cause	of death (Iter	m 23a) (Type, (Man L	erint) HI1001	s Bac	Vimore	Ma	2120	4		
Stat	e	31. Date filed (Month, Da		7 32. Re	gistrar's Sigr	ature	s Hreel		- 51.55 (0)	•	-1	<u> </u>		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death HENRY JANUARY LEIKACH 2012 1:00 A 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death MILFORD MANOR NURSING HOME BALTIMORE BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth 1 X M 2 □ F Days Months 0772771946 219-44-5191 65 POLAND Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No BALTIMORE BALTIMORE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 9105 RUTH ELDER LANE 21208 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: WHITE 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ PHARMACIST PHARMACOLOGY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) LEIKACH JENNTE KATZMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EILEEN LEIKACH/WIFE 9105 RUTH ELDER LANE, BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) BALTIMORE HEBREW CEM 01/24/2012 REISTERSTOWN, MD 21. Signature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Laue to (or as a consequence of): BOIOU Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death 2 No Unknown g 🗌 Unknown

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Division of Vital Records, P.O. Box 68760

Physician/

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Baltimore, Maryland 21215-0036

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if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical

☐ Accident☐ Suicide

23e. Did tobacco use contribute to the cause of death 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

246. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No

26. Place of Death (Check Hospital 2 NA 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner 28b. Time of 5 Pending atural injury

28c. Injury at

5 Residence 6 Other (Specify, 28d. Describe how injury occurred

only one)

work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number,

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Sign

30. Name and address of person

Investigation 6 Could not be

determined

31. Date filed (Month, Day, Year) State Registrar

32. Registrar's Signature

and title of certifier

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 01560 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 Pearl Marjorie Moore January 5:50 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Mallard Bay Nursing & Rehab Cambridge Dorchester If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Dec 9, 1928 5. Social Security Number 7. Age (In vrs. last hirthday) **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🗓 F Months Country) Maryland Director Yrs 213-24-4993 83 Usual Residence of Decedent 10a, State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f sh must be notified a MD Dorchester Cambridge 1 Yes 2 No 10e. Street and Number 10f. Zip Code 21613 10g. Citizen of What Country? Funeral 520 Glenburn Ave. "natural", or items dical Examiner mu death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ♠ No 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i any injury or other traumatic event the contraction. Black White etc þ 1 Never Married 2 XMarried 1 Yes 24 If Yes, Give Year or Dates. Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) United States Elementary/Seconday (0-12) College (1-4 or 5+) 12 0 mail courier Postal Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Frazier Gerald Vincent Pearl Lowe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George D. Moore - husband 1107 Holland Ave; Cambridge, MD 21613 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify) cemetery, crematory or other placel dre Funeral Service Lice Sign 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, wheart failure. List only one cause on each line. Approximate shock Interval Between Immediate Cause (Final Onset and Death enysician/ 100011 disease or condition resulting in death) Medical Due to (or as a Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial-t Physician/Medical Division of Vital Records, P.O. Box 68760 attending ph I for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 D Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 5 Other (specify) Year Pregnant at time of death the detached been signed by i should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ♣No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No page 2 certificate 1 | Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 10 Hospital: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at within 24 hours after death.

To the Funeral Director: After 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation filled in by the 6
Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Murse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature 29d. Date signed (Month, Day, Year) ss of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Joseph Medical 4a. Facility Name (if not institution, give street and number) County of Death **Examiner** Allegan Cumbuland VA Clivic, Zoo Glenn umber land 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under **Funeral** Hours Min 54 478 Director 1 🗙 M 2 🗆 F Ohio 64 or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Examiner must be notified at Director 1 🗌 Yes 2 🔀 No NU FORE! 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral or items 23a RRI 26767 death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status rmed Forces?

Yes 2 No Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. Specify: White "natural", 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) a countent Important: If item 27 is marked other any injury or other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8004 Caradoc Dr; Balto, MD 21227 Lisa Miklewski - daughter 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Page 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) in state cemetery, crematory or other place) Signal re o Speral Service L 22. Name and Address of Facility State Anatomy Board Rona 655 W. Baltimore St; Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, rheart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Phyllician Due to (or as a consequence of) disease or condition resulting in death) Medical Examiner CAD Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Year in the past 12 months? Day Pregnant at time of death signed by the at d be detached f Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed should 24b. Were autopsy findings available prior to completion of cause of death? By 5/- pidounsa 24a. Was an page 2 s autopsy performe within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 X No 1 Inpatient 2 KER/Outpatient 3 IDOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: iniury 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number

State Registrar 31. Date filed (Month, Day, Year)

erson who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month AGNES MCDERMOTT 11: 56 PM JANUARY 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GOOD SAMARITAN HOSPITAL BALTIMORE N/A Social Security Number If Under 1 Year If Under 24 Hrs. 6 Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday, **Funeral** Hours Director 219-20-6962 1 M 2 X F 10/4/1926 MARYLAND 28a-f shov aţ 10c. City, Town or Location 10d. Inside City Limits Director "natural", or items 23a or 28a-f s edical Examiner must be notified 1 Yes 2X No BALTIMORE TOWSON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8318 LOCH RAVEN BLVD. 21286 USA death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Completed by 1 Never Married 2 X Married 1 Yes 72 hours after Maryland 21215-0036 1 Yes 2 No Specify: Specify: WHITE 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) PRIVATE SCHOOL BOOKKEEPER 12TH GRADE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ MARY GIENKOWSKA VINCENT CZOSNOWSKA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sł Department of Health ar Important: If item 27 is any injury or other trau 8318 LOCH RAVEN BLVD. TOWSON, MD ALBERT J. MCDERMOTT/HUSBAND Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 Burial 2 XCremation 3 Removal from State 4 Donation 5 Other (Specify) METRO CREMATORY, INC. 1/27/2012 | CATONSVILLE, MD 21. Signature of Euneral Service License 400217 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ RESPIRATORY FAILURE HYPOXIC. Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last and burial-trai Due to (or as a consequence of): MCDERMOTT Physician/Medical Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death Unknown 1 ☐ Yes ∠ ™ P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ျ 4 Nursing Home 5 Residence 6 Other (Specify) 1 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending work? 1 ☐ Yes 2 ☐ No 1 Natural injury 5 Pending after death. Director: Af ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Eyasu Mekonen, M.D. D64312 January 22, 2012 Sh Eyasu Mekonen, M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore Boulevard, Raven 5601 Loch Date filed (Month, Day, Year)

JAN 2 5 2012 Registrar's Signature

DHMH 17 Rev 06-2011

Registrar

AGNE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month Physician/ DALE, MCLAUGHLIN 7:49PM GARLAND, TANUARY 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HARBOR HOSPITAL N/A BALTIMORE 5. Social Security Number Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Unde **Funeral** Hours **Director** 233 34 1247 1 X M 2 D F 86 03/28/1925 West Virginia Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notifiled at 10b. County 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Baltimore Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21225 U.S. 5213 Ballman Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces? Completed by 1 Never Married 2 Married Yes Yes, Give Maryland 21215-0036 1 Yes 2 XNo Specify: White Specify. WW II 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry al Hygiene. life DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Iron Worker's Local Iron Worker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental ! ပ Monta McLaughlin (unknown) permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Claudette McLaughlin / Daughter 504 Kosoak Road Middle River, Maryland 21220 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 01/25/2012 Baltimore, Maryland 4 Donation 5 Other (Specify) Cedar Hill Cemetery 21. Signature 22. Name and Address of Facility Gonce Funeral Service, P.A. Baltimore, Maryland 21225 4001 Ritchie Highway 23a. Part 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph_sician/ ASPIRATION PNEUMONIA disease or condition Medical resulting in death) Due to (or as a consequence of Examiner FAILURE KENAL Sequentially list conditions, Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death been signed by the 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy death? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 1 Tes မ ER/Outpatient 3 DOA 1- Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After injury Natural 5 Pendina 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number RES OOI JANUARY, 21, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 SOUTH HANOVER STREET, BALTIMORE, MD 21225

Registra

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MOSPITAL,

32. Registrar's Sig

HARBOR 31. Date filed (Month, Day, JAN 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ McClellan Janie Κ. 2012 2:40 РΜ January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8528 Pleasant Plains Rd. Baltimore Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Year) Min Days Hours 216-56-6855 1 - M 2 - F Director 87 Virginia Sept 22, 1924 Usual Residence of Decedent show 10a. State 10c. City, Town or Location the Maryland notified at Director 28a-f 1 Yes 2X No Baltimore Towson MD. 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number ms 23a or must be r Funeral 8528 Pleasant Plains Rd. USA 21286 permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Was Decedent Armed Forces?

1 Yes 2 No 14. Race - American Indian, 11 Marital Status ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify. White Specify. 3X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Interior Decorating Sales Manager 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Bayne Mary David Kinkaid 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8528 Pleasant Plains Rd. Towson, MD. 21286 Melissa McClellan/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Towson, MD. 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Co. 1-24-12 22. Name and Address of Townson Funeral Home, 21. Signature Funeral Service Lice see 1050 York Rd. Towson, Md. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. 23a. Part 1 Approximate Interval Between Onset and Death Immediate Cause (Final STROKE Physician/ MINUTES disease or condition Medical resulting in death) Due to (or as a consequence of) CETTEBROVASCIAM DISEASE **Examiner** VEARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last for use as the burial-tran Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No Month Pregnant at time of death Other (specify) Unknown sate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by MBM 1ATTON 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of Dementia 24a. Was an autonsv perform death? Yes 2X No certificate 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Medical Certificate: 28d. Describe how injury occurred injury 1 🗸 Natural 5 Pending 24 hours after death. Funeral Director: A Accident Investigation filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

within 2 To the F To the

> Registrar DHMH 17 Rev 06-2011

only one)

29b. Signature and title of certifier

JAN 2 5 2012

RICHARD O'MAILEY, MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra/s Signature

29c. License number

D0047625

7600 OSLER PrivE, Svife 311. TOWSON, mp.

29d. Date signed (Month, Day, Year) 1/23/12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Deatl Physician/ Month 12:30A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Columbia Howard **Howard County General Hospital** If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Davs Hours Min (Month, Day, Year) Jul 11, 1959 217-64-3656 52 MD 1 □ M 2 💢 F Director show 10d. Inside City Limits ms 23a or 28a-f sho must be notified at 10a. State 10b. County 10c. City. Town or Location with the Maryland Director MD Columbia Howard 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 8646 Hayshed Lane 21045 U.S.A. items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Examiner Armed Forces? ō ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 No Specify: White If Yes, Give Year or Dates Specify: 3 ☐ Widowed 4 ☐ Divorced "natural", Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) **Adjunct Faculty Member** Education event, 1 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) th and Mental H 27 is marked of traumatic ever ဂ Michael J. Pedone Margaret Rosalie Gugerty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health al Important: If item 27 is any injury or other trau Robert G. May 8646 Hayshed Lane Columbia, MD 21045 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Jan 20, 2012 Clarksville, Maryland Columbia Memorial Park 22. Name and Address of Facility
Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner UNO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine the burial-transit Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has page 2 1 Yes 2 No 2 1 Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 Yes 2 No 1 Inpatient 2 I ER/Outpatient 3 I DOA After this 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 ANatural 5 Pending work?
1 Yes 2 No 24 hours after death. Funeral Director: Al Accident Investigation filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined

within 24 hou

To the Fune

completely fi

Registrar

Medical

31. Date filed (Month. Day. State

29a. Certifier

(Check

29c. License number

TIMORE

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SLC

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Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
AMEND TIEM#30perDVR, G923, Inc. 5, 2012, WS
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 21 2012 ea JANUARY 7:40 PM MERMELSTEIN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CASEY HOUSE ROCKVILLE MONTGOMERY Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth Funeral (Month, Day, Year) 292-28-7934 **Director** 1 X M 2 □ F 85 07/28/1926 |CZECHOSLOVAKIA 28a-f shov 10d. Inside City Limits 10b Count 10c. City, Town or Location be notified at Directo 1 Yes 2 X No MD MONTGOMERY ROCKVILLE 10e. Street and Number 10f. Zip Code 0 10g. Citizen of What Country? 23a Funeral event, the Medical Examiner must 20852 1801 EAST JEFFERSON STREET or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: 3 X Widowed 4 Divorced Completed WHITE Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) BUSINESS OWNER AUTOMOTIVE RECYCLING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ BARUCH WEISMAN MALKA MERMELSTEIN injury or other traumatic and 2 should be Health and Metern 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6921 ARMAT DRIVE, BETHESDA, MD 20817 ELLIOTT PORTNOY/SON-IN-LAW item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗌 Cremation 3 🔀 Removal from State HAR HAMENUCHOT 01/22/2012 4 Donation 5 Other (Specify) JERUSALEM, ISRAEL 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC any Mast Lei 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CORONARY ATHEROSCLEROSIS disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) Due to (or as a consequence of) burial-t resulting in death) Last attending physician Physician/Medical law requires that the death certificate be as the IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy ò in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, PARKINSONS DISEASE 1 Yes 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an PROSTATE CANCER has page 2 autopsy nerformed' 1 Yes 2 No 1 Yes 2 X No 25. Was case referred to medical examiner?
1 ☐ Yes 2 🏋 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE မ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director; After this completely filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 L 3 L only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D37142 1/21/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COLEMAN, M.D., Casey House Rockville, Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ OFFIT JANUARY 23, 2012 9:36 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SINAI HOSPITAL BALTIMORE N/A 5. Social Security Number 6. Sex 1 X M 2 □ F 7. Age (In vrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days Hours 0870771925 Director 219-12-7769 86 MD Usual Residence of Decedent or 28a-f show notified at 10b County 10a. State 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 Yes 2 No BALTIMORE BALTIMORE 10e. Street and Number ō 10g. Citizen of What Country? must be Funeral 23a 3407 OLD POST DRIVE 21208 USA items ı "natural", or item ledical Examiner n Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces?

1 4 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Completed | 3 ☐ Widowed 4 ☐ Divorced WHITE Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) alth and Mental Hygiene.
27 is marked other than a traumatic event, the M Elementary/Seconday (0-12) College (1-4 or 5+) CERTIFIED PUBLIC ACCOUNTANT ACCOUNTING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ SAMUEL OFFIT CELIA BLACKER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a EILEEN OFFIT/WIFE 3407 OLD POST DRIVE, BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 0 = i 1 X Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once, 4 ☐ Donation 5 ☐ Other (Specify) BETH EL MEMORIAL PK :01/24/2012 RANDALLSTOWN, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Ph_sician/ ventruler techywordie Medical resulting in death) Due to (or as a consequence of) Examiner 107013 coronery artery disco Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last sician and burial-tran Due to (or as a consequence of) attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 as the l IF FEMALE: nse yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Live Greath ☐ Ectopic pregnancy ☐ Other (specify) ____ ò in the past 12 months? Month signed by the a 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pymonory Abrosis Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Yes 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\to \) Nursing Home 5 \(\to \) Residence 6 \(\to \) Other (Specify) 2 X No မှ 1 ☐ Inpatient 2 MER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred ■ Natural injury 5 Pending Investigation Accident completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 1/23/12 Kichendo Berg AD 20020604 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

2 5 2012

Richard A. Berg. 40; Svite 260; 2700 Querry take Drive, Seltimore, 44 21209 32. Registrar's Signature

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene $2\ \tilde{0}\ |\ 2$ State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 11:33 AM January Carol Evon Payne-Jackson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 5171 Frederick Avenue If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month Day, Year) | 55 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** MD **Director** 1 □ M 2**火** F 56 216-68-4703 Usual Residence of Decedent , or items 23a or 28a-f show miner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 1 X Yes 2 □ No Baltimore MD NA The Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. Funeral 21229 5171 Frederick Ave 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14, Race - American Indian, 11 Marital Status "natural", or iter Armed Forces?

1 Yes 2 No Black, White, etc 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes Give Specify: Black 3 Widowed 4 ☐ Divorced Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) ie 1 and 2 should be filed within 72 t of Health and Mental Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) State of Maryland 2yrs+ Secretary 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Irma Payne Floyd Walker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8660 Cobblefield Drive apt 1A, Columbia, April Brown-Daughter 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, Page 1 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) ō Important: If any injury or once. 1/25/2012 Owings Mills, Md Garrison Forest Signal re if uneral Service Licepage Manuford Address of Wells t 4300 Wabash Ave, Baltimore, Md 21215 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final natural Physician/ De Consequences resulting in death) Medical Due to (or as a consequence of): Examiner DPD Sequentially list conditions, if any, leading to immediate cause in the Unorthing Cause (Disease or injury Due to (or as a consequence of OR B burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical P.O. Box 68760 as the b IF FEMALE Jse 8 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) ____ for Month Day Year Pregnant at time of death the a 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 EYes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2: autopsy performed 1 🗆 Yes 2 🗆 No 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at 1 Natural work? iniury 5 Pending Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 43172 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Fair night fre Towson, MD 212.86 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Parker 2012 7:25 Haze1 January Marie Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington 17110 Reedy Parkway Hagerstown Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) <u>Funeral</u> Hours Director 1 □ M 2XXF 578-90-0065 61 March 20,1950 Maryland Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or items 23a or 28a-f shominer must be notified at Director 1 Yes 2 No Maryland | Washington Hagerstown 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral U.S.A. 17110 Reedy Parkway 21740 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Page 1 and 2 should be filed within 72 hours after death 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status the Medical Examiner Armed Force Black, White, etc. 1 Never Married 2 Married ☐ Yes 2.X No þ Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give "natural", Completed 3 Divorced 4 Divorced White Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 0 Helper Vocational other lith and Mental Hygie 27 is marked other r traumatic event, the Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Duffy Harry Parker Theresa M. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau WCHDC 433 Brewer Ave. Hagerstown, Maryland 21740 Carmen Bundick / Agency 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/20/2012 Hagerstown, Maryland Rest Haven Cemetery 21. Signatur of Funeral Service Lines 22. Name and Address of FacilityRest Haven Funeral Chapel 1601 Pennsylvania Ave Hagerstown Maryland 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 3 Years Immediate Cause (Final Ph_sician/ Dementia disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trar Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 as IE FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Month Pregnant at time of death Yes 2 🖾 No ed by the a detached 1 9 Unknown 9 Unknown ate has been signed by a page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 → No 3 ☐ Probably 4 ☐ Unknown Downs Syndrome 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? After this certificate | 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral o 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 1 X Natural 5 Pending injury work' Accident 1 Yes 2 No Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) 10 18/2012 R128088 Kate in Smith

Registrar

Hagerstown, MD 21740

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Date filed (Month, Day, Year)

2 5 2012

32. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) Month Physician/ Margaret Evelyn Rihtaric 7:00 A.M 2012 January Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Glen Burnie 7122 Baltimore Annapolis Blvd. Anne Arundel If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Numbe Age (In yrs. last birthday) 8. Date of Birth **Funeral** Country) Maryland Days Hours Months 1 🗌 M 2 🕱 03/24/1957 215 86 2027 54 Director Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State Director 1 Yes 2 X No Glen Burnie Maryland Anne Arundel 10g. Citizen of What Country? 10e. Street and Number U.S. Funeral 21061 7122 Baltimore Annapolis Blvd. within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 X Never Married 2 Married "natural", or þ Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify If Yes. Give White 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filled within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) 12th College (1-4 or 5+) Shop Rite Produce Department Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anna M. Rihtaric Samuel R. Barrett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Glen Burnie, MD 21061 7122 Balto. Annapolis Blvd. Rosemarie Tillman / Sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) 1 🗆 Burial 2 🕱 Cremation 3 🗀 Removal from State any injury or 01/25/2012 Baltimore, Maryland Bayview Crematory 4 Donation 5 Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. Signature of Funeral Service License Baltimore, Maryland 21225 4001 Ritchie Highway Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final and Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of Exami The law requires that the death certificate be executed and -trans that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burlal-Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death 1 Yes 2 Unknown signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ Unknown 2 🗌 No Division of Vital Records, Completed been s 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? page 2 s autopsy performe 1 🗌 Yes 2 🗍 No To the Funeral Director; After this certificate completed filled in by the funeral director, pag To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certific 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 I DOA 1 Tes ဂ္ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: Natural injury 5 Pending 1 Yes Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certify 30. Name and address of person who completed cause of dead 31. Date filed (Month, Day,

Registrar

DHMH 17 Rev 7/2009

State

5 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JAN. Physician/ 5534M MELVIN D. REUBER 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Columbia Howard County General Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) Months Director 509-28-7941 1 🛛 M 2 🗆 F Nov. 10, 1930 Kansas 81 Usual Residence of Deceden 28a-f show 10d. Inside City Limits at 10a. State 10b. County 10c. City. Town or Location Director "natural", or items 23a or 28a-f s edical Examiner must be notified 1 X Yes 2 No Maryland Howard Ellicott City 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21043 U.S.A. 3435 Plim Tree Drive #B death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc. by 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Completed 3 Divorced 4 Divorced Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4 or 5+)
5+ Elementary/Secondary (0-12) Cancer Research Medical Pathology ith and Mental Hygie 27 is marked other r traumatic event, th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Amanda Johanna Michel Frederick William Reuber permit, Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24805 Ludell Rd., Ludell, Kansas 67744 Eugene Reuber (Brother) 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place)
Metropolitan Crematory 1/19/2012 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State Alexandria, VA ponation 5 Other (Specify) 22. Name and Address of Facility
METROPOLITAN FUNERAL SERVICE
5517 VINE STREET ALEXANDRIA, Signature of uneral Service cer 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death SEPTIC SHOCK Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner GRAM NEGATIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine INFECTION To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after neath Cause (Disease or injury that initiated events URIVARY TRACT Due to (or as a consequence of) resulting in death) Last physician s the buria Physician/Medical P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? þ Month Day Pregnant at time of death Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à ACUTE TURYLAR NECROSIS Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an RESPIRATORY FAILURE page 2 s has HYPO GLYCEMIA 1 Yes 2 No certificate Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? 1 Yes Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 Denpatient 2 ER/Outpatient 3 DOA ည 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: eral Director; After filled in by the funer 1 Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 8004 366 JAN 17,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William BOYCE Howard Co 17 3

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mathilde Louise Rehberger Jamuary 21ay 2012 1:45 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Oak Crest Care Center Baltimore Baltimore **Funeral** If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign 216-16-4416 1 🗆 M 2 🗶 F Days JuMoyth, 12, Year 1910 Director 101 Marviand Usual Residence of Decedent or 28a-f show 10c. City, Town or Location notified at 10d. Inside City Limits Director Maryland Baltimore Parkville 1 🗆 Yes 2 🕇 No 10e. Street and Number 10f. Zip Code er than "natural", or items 23a or the Medical Examiner must be 10g. Citizen of What Country? Funeral 8800 Walther Blvd 21234 u.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black White etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: White Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry should be filed within 721 nand Mental Hygiene.
7 is marked other than "n (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Otto Fleischmann Mary Marousek permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grand Betsy Honbarrier Pfund/daughter 2136 Sonnythorn Road, Middle River, Maryland 21220 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 1/25/2012 Parkville, Maryland 21. Signature of Fune 22. Name and Address of Facility Ruck Towson Funeral Tome, Towson, Maryland 1050 York Road 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ cration disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any leading to mind cause. Enter Underlying Cause (Disease or injury that initiated as or injury Examine or Attending Physician: The law requires that the death certificate be executed the burial-tran that initiated events resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Dav Year 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed? Yes 2 No certificate 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? No Hospital Other: Certificate: To within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending injury work' Accident
Suicide 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) within 24 hours To the Funeral L To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 23 Ceptifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature M

Registrar

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.

AMEND TIEM#14, 18 perf H, 6924, 27672012, WS

State of Maryland / Department of Health and Mental Hygiene

1 - State of Maryland / Department of Death

Reg. No.

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 20/2 620 (2) a m Medical 4a. Facility Name (if not institution, give street and 4c. County of Death **Examiner** 4b. City, Town, or Location of Death 5 D CY054 VEX 11mg Day 150 out 27 If Under 1 Year | If Under 24/Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 D F Days Month, Day, Ye 185-40-0789 Months Hours Min **Director** Usual Residence of Decedent or 28a-f show 10d. Inside Cjty Limits 10a, State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland at 10c. City, Town or Location Director must be notified 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 23a , or items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Examiner Black, White etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes Give "natural", Completed 3 Widowed 4 Divorced 100Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) marked other than matic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. OV Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Okane Elizabeth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health and tem 27 is r Department of Health Important: If item 27 any injury or other trong. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Termation 3 Removal from State 4 Dopetion 5 Other (Specify) tanover trdent 21. Signature of Puner-I Service Lice 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ 11CATOD disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of Tospital or Attending Physician: The law requires that the death certificate be executed and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown Yes 2 No the 9 Unknown detached **Director:** After this certificate has been signed by in by the funeral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: s after deatn.

al Director: After this control director director. 2 No ဂ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident iniury 5 Pending 4 1997 1 Yes Investigation 730 M 53 NA 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) City or Town, State) 9 Dr within 24 hours a

To the Funeral I 2104 Medical 1 X Certifying Physician: To the best of my knowledge, death occured at he time, date and place, and due to the suse(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d, Date signed (Month, Day, Year) D0069820 OBOX 2613, SALISBURY State 5 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Marc 2300 anuary 2012 4a. Facility Name (if not institution. give street and number 4b. City, Town, or Location of Death 4c. County of Death ltimore N/A 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) rs. last birthday 219-38-8013 1**X**□ M 2 □ F 69 02/10/1942 MA Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3401 BONNIE ROAD 21208 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 XNo Specify. 3 Widowed 4 Divorced Specify: WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) ADMINISTRATOR STATE OF MARYLAND 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JOSEPH RASH COFFMAN H. DOROTHY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HARRIET RASH/WIFE 3401 BONNIE ROAD, BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State HAR SINAI CEMETERY 01/20/2012 OWINGS MILLS, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sen 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death disease or condition resulting in death) Due to (or as a onsequence of) Due to (or as a consequence of) Due to (or as a consequence of):

Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any injury or other traumatic event **... Ph. sician/ Medical **Examiner** Examiner executed burial-tra

physician

as

that the death certificate be Box 68760

P.O.

Division of Vital Records,

To the Hospital or Attending Physician: The law requires

After this certificate has

director,

filled in by the funeral

within 24 hours after death.

To the Funeral Director: Air completely filled in by the fu

Be

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Certificate:

Medical

Physician/

Medical

10a, State

MD

Director

Funeral

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Completed

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Examiner

Funeral

Director

28a-f show at

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"natural", or

Baltimore, Maryland 21215-0036

notified

Examiner must be items 23a

Medic

Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant

IF FEMALE

23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death

Physician/Medical in the past 12 months? 2 No 9 Unknown þ Completed

25. Was case referred to medical

4 Homicide

29a. Certifier

9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pregnant at time of death

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an

death? 1 Yes 2 No

28f. Location (Street and Number or Rural Route Number,

23d. Date of delivery

1 Yes 26. Place of Death (Check only one) Hospital 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 4 Nursing Home 5 Residence 6 Other (Specify)

3 Ectopic pregnancy 5 Other (specify) ___

2 No 1 Yes Date of injury (Month, Day, Year) 27. Manper of Death 28b. Time of Natural 5 Pending iniury Accident Investigation 6 Could not be Suicide

determined

sorde

28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No

autopsy

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print)

Himore 401 plued 32. Registrar's Signature

State Registrar

31. Date filed (Month, Day, JAN 25

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Physician/ Kombro 10:15A M Max January Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner RANDALLSTOWN BALTIMORE SEASONS HOSPICE @ NORTHWEST HOSPITAL 9. Birthplace (State or Foreign . Social Security Number 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day, Year) **Director** 213-12-9938 1 🕅 M 2 🗆 F 93 03/03/1918 Usual Residence of Deced 28a-f shov 10d. Inside City Limits 10b. Count 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if firem 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 X No BALTIMORE PIKESVILLE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral USA 21208 8911 REISTERSTOWN ROAD 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married I X Yes 2 □ No f Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 X Widowed 4 ☐ Divorced Completed WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) CLOTHING 12 **MANUFACTURER** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည ROMBRO **MYERS JACOB** ELSIE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7941 STARBURST DRIVE, PIKESVILLE, MD 21208 RICHARD ROMBRO / SON Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State BALTIMORE HEBREW CONG 1/22/2012 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Ferral Service Lice 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph, sician/ End. Stage Dementra disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) the burial-tran Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 IE EEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Pregnant at time of death Yes 2 No 9 Unknown Unknown Hospital or Attending Physician: The law requires that the 1.24 hours after death.
Funeral Director: After this certificate has been signed by th Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? performed? Yes 2 N 1 Yes 2 No completely filled in by the funeral director, 25. Was case referred to medical examiner?
1 Yes 2 No Be (26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Other (Specify) Other: မ 1 Inpatient 2 I ER/Outpatient 3 I DOA Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at injury 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated United Description Surse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier Mostly spanning 00057465 1/19/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N.S. Ray Mp also, M.D. 1835 Smith AV 5 203 Bultimore MD 21209

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10f Per ANA BD G923 1/25/2013 THE State of Maryland 7 Department of Health and Mental Hygiene For State Registrar Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 20°12 January 16 12:56 AM Tamara Schaller Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Arundel Anne Arundel Medical Center Glen Burnie Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Hours Nov 22, 1945 Washington DC 266-88-5306 66 Director 1 🗆 M 2 🗓 F Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Director 1 Yes 2 X No MD Annapolis Anne Arundel 10e. Street and Numbe or 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 21403 21043 USA 900 Van Buren St. filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. or þ 1 X Never Married 2 Married white If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working (Specify only highest grade completed) al Hygiene. life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Ó disabled none Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F မှ pe Norman Schaller Tita Turner permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2605 Soapstone Dr; Reston, VA 20191 Sherry Marshall - sister Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Nother (Specify) in State
Simple of Funeral Service Wadd, Dire cemetery, crematory or other place) 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or conditions) Approximate Interval Between Onset and Death -Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) and Due to (or as a consequence of): attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No 24a. Was an performed within 24 hours after death.

To the Funeral Director: After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending ☐ Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one 29b. Signature and title of certifies 29c. License number 29d, Date signed (Month, Day, Year) SAN 16, 2012

Registrar

DHMH 17 Rev 06-2011

State

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Division of Vital Records.

Annalis MD 21401

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar' Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Sm; TH Physician/ ORES Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Seasons Hospice at Northwest Hospital Randallstown Baltimore Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min (Month, Day, Year) 82 **Director** 215-40-9828 1 M 2 XF 24, 1929 Maryland show 10a. State 10c. City, Town or Location notified at 10d. Inside City Limits Director 28a-f MD Baltimore North Linthicum 1 Yes 2 X No 10e. Street and Number 10f. Zip Code ms 23a or must be n 10g. Citizen of What Country? Funeral 11 Hampton Rd. 21090 USA Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iten edical Examiner n 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black White etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) housewife own home of Health and Mental Hygiei If item 27 is marked other r other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Delph Marhsall Uphold Eva Alice Parsons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11 Hampton Rd; N. Linthicum, Maryland 21090 Sonya Smith - daughter t of Healt : If item? / or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Department of Important: If any injury or 4 X Donation 5 Other (Specify) 22. Name and Address of Facility State Anatomy Board Signature of Funeral Service Lice 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, on real failure. List only one cause on each line.

Immediate Cause (Final disease or conditions) Approximate Interval Between Physician/ disease or condition 050 Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of, burial-trar Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 as the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy signed by the atter d be detached for in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Other (specify) 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably Inknown 24a. Was an 24b. Were autopsy findings available After this certificate has autopsy perform prior to completion of cause of death? Yes Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: ည 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 27. Manner of Deat 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred 1 Natural 2 Accider 5 Pending injury Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the only one 29b. Signature and title Date signed (Month, Day, Year) မ

State Registrar

31. Date filed (Month, Day,

ame and address of person who completed cause of death (Item 23a

5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible? State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Day Year Wayne Edmond Stewart 3.59P Medical 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9 Bruber Court Baltimore Gwynn Oak Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex If Under If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min (Month, Day, Year) Director 213-64-5300 1**X** M 2 □ F 55 May 30, 1956 Mary land Usual Residence of Deceden show 10a. State 10b Count 10c. City. Town or Location 10d. Inside City Limits with the Maryland notified at Director 28a-f Mary.land Baltimore 1 Yes 2X No Gwynn Oak 10e, Street and Number 10f. Zip Code ь 10g. Citizen of What Country? ms 23a or must be r Funeral 9 Bruber Court Apt.1B 21207 USA death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Black, White, etc. 5 þ Examin 1 Never Married 2 Married Yes 2 No Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: Black "natural" Completed 3 Widowed 4 Divorced er than "natur the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th grade <u>Public School System</u> Teacher other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H 27 is marked of traumatic ever ၉ Leon C. Stewart Dorothy Orrbright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a lf item 27 is or other tra Robin Stewart-Willis/Sister 2422 Barnesley Place Windsor Mill, Maryland 21244 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State -24-2012 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State = 6 Department o Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Greenmount Cemetery Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Chatman-Harris Funeral Home arri 5240 Reisterstown Road Baltimore, MD 21215 23a. Parv. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Ecquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami the burial-trai Due to (or as a consequence of) physician Physician/Medical the Hospital or Attending Physician; The law requires that the death certificate be P.O. Box 68760 use as attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death signed by the a signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page 2 s 1 ☐ Yes 2 ☐ No 25. Was case referred to medical the funeral director, 26. Place of Death (Check only one Certificate: To Be Other: 2 X No 1 Yes 4 Nursing Home 1 Inpatient 2 I ER/Outpatient 3 I DOA 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Suicide 3 ☐ Suiciae 4 ☐ Homicide . Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month. 30. Name and address of person who completed cause of death (Item 23a) (Type/P

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19a Per INF G924 2/09/2012 JH
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 19 2012 08:36 Peele Scott January Juanita Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** George's 5501 Norfield Rd. Capitol Heights Prince 7. Age (In yrs. last birthday) If Under 24 Hrs Hours Min. 8. Date of Birth (Month, Day, Year, pril 30. 9. Birthplace (State or Foreign Social Security Numbe **Funeral** Days Months North Carolina 1 □ M 2 🗓 F 035-20-3373 91 **Director** 920 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1X Yes 2 □ No Maryland Prince George's Capitol Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with Funeral 20743 U.S.A. 5501 Norfield Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Black 3 X Widowed 4 Divorced Completed Page 1 and 2 should be filed with the part of Health and Mental Hyglene. Trant: If item 27 is marked other than "natur mant: event, the Medical." 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Home Economic Extention Agent 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lizzie Goddard ည John B. Peele 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19 Informant's Name (Relationship Type, Print) 125 Wilson St., Keysville, VA 23947 Kay Scott (Niece) 20a. Method of Disposition
1 → Burial 2 → Cremation 3 → Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date Department of I Important: If ite any injury or ot Mounter Engly or other place)
Baptist Church Cem. 1/28/2012 Keysville, VA 4 Donatton 5 Other (Specify) 22. Name and Address of Facility
METROPOLITAN FUNERAL SERVICE;
5517 VINE STREET, ALEXANDRIA; 21. Sign ture of Huneral Service Licensee ren 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Hypertensive Cardiovascular Disease disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical I or Attending Physician: The law requires that the death certificate be after death.
Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3

Ectopic pregnancy in the past 12 months?
1 Yes 2 X No Month Year Day 5 Other (specify) Pregnant at time of death signed by the a'd be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypothyroidism 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔯 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Diabetes autopsy page 2 performed? death? 1 ☐ Yes 2 ☐ No Dementia funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 ☐ Yes 2 🗓 No Medical Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 X Natural injury 5 Pending 2 Accident Investigation completed filled in by the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours Hospital Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) and the of certifie 29c. License number 29b. Signatur Jan. 20, 2012 D52900 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12150 Annapolis Rd. #205, Glen Dale, MD 20769 Musa Momoh, M.D. 31. Date filed (Month, Day, Year) Registrar's Signature State parker JAN 2 5 2012

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Day ERNEST 12:50 PM 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL RANDALST BALTIMORE OWN If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year 6. Sex 8. Date of Birth Funeral Date or D. (Month, Day Days Months 1 M 2 □ F Min Yrs 75 Director 212-30-4953 08 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits aţ 10c. City, Town or Location Director notified Owings Mills 1 Yes 2 No Baltimore MD 10g. Citizen of What Country? 5 10e Street and Number 10f. Zip Code er than "natural", or items 23a or the Medical Examiner must be r Funeral U.S.A. 21117 9 Mill Pond Court death v 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+ Il Hygiene. Assembly Line Worker General Motors 10th grade na Be filed 17. Father's Name (First, Middle, Last) Unknown 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers is marked o permit. Page 1 and 2 should be 1. Department of Health and Mental Important: If item 27 is many injury or other. 2 Atlie Sykes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9 Mill Pond Court, Owings Mills, Md 19a. Informant's Name/Relationship (Type, Print) 21117 Albertha Sykes-Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State Baltimore, Md On-Site 1/30/2012 4 ☐ Donation 5 ☐ Other (Specify) ure of Funeral Service Licensee March F/H West 21215 4300 Wabash Ave, Baltimore, 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest lock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death CARDIOVASCULAR DISEASE Ph_sician/ ATHEROSCLEROTIC disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence oi) attending physician and the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 use as yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) Month Pregnant at time of death signed by the a 9 Unknown To the Hospital or Attending Physician: The law requires that the within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 W Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 autopsy performed Yes 2 2 No 1 Yes 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) Hospital: ပ ER/Outpatient 3 DOA 1 Inpatient 2 🗹 28a. Date of injury (Month, Day, Year) 27. Man, er of Death 28b. Time of Certificate: 28c. Injury at work?
1 ☐ Yes 28d. Describe how injury occurred Natural 5 Pending injury 2 🗆 No 2 Accident Investigation completed filled in by the 6 Could not be 3 Suicide
4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) 2012

Registrar
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Ore Medical acility Name (if not institution, give street and number 4b. City, **Examiner** County of Death Hours Min. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral Director** 1 M 2 NF Usual Residence of Decedent 28a-f show 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10b. County 10d. Inside City Limits **Funeral Director** must be notified 1 Nes 2 No 10e. Street and Numbe ō 10f. Zipk 10g. Citizen of What Country? 23a items ? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent Ever in U.S. Examiner Armed Forces? 0 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates Specify "natural", Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. life. DO NOT use retired) econdary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ 19b. Mailing Address (Street and Number or Rural Route Number, City 🖣 Town, State, Zip Code) 19a. Informant's Name/R lationship (Type, Print) Mr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) Mb permit. Home; Signatu neral NOV 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a nsequence) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Dav Year Pregnant at time of death been signed by the salud be detached a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Nown To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an cate has I autopsy 24 hours after death. Funeral Director: After this certificate 1 Yes 2 No Yes 2 AN filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manper of Death Certificate: 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 🗌 No Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 1(Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one 29b. Signature and title of cer 29d. Date signed (Month, Day, Year) 2 1ens 20/2

State Registrar 30. Name and address of person who completed cause of death

12 ALLEN W.

31. Date filed (Month, Day, Year)

MELKITT

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(Item 23a) (Tope,

mitte

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32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Melvin Schultz, Sr. 2012 3:10 A M January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Greater Baltimore Medical Center Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** July 10, 1917 Days Hours Maryland 220-01-3270 94 Director 1 🛛 M 2 🗆 F Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County Director notified MD Baltimore Lutherville 1 Yes 2 X No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ō ms 23a or must be n Funeral 1015 Chestnut Ridge Drive U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items: any injury or other traumatic event, the Medical Examiner musone. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: White 3 XWidowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) **5+** Western Electric Electrical Engineer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Schultz Adela Mussinski James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Krista Schultz-granddaughter 1015 Chestnut Ridge Dr., Lutherville, MD 21093 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Dulaney Valley 1 X Burial 2 Cremation 3 Removal from State 1/23/12 Timonium, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Signature of Funeral Service Licensee William G. Dau W 1050 York Rd., Towson, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ signed by the atter in the past 12 months? Month Day Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PATERIAL HYPERTENSION, RBBB 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Parkinsons disease 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA မ 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 5 Pending 1 Natural after death. 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours a Funeral I Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hou To the Funel completely fi 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) hole 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

ADOLFO

8415.

Bellong Lane Towson KAD 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIEM#30perDVR, G923, 1, 257, 2012, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Year **Physician** illian Sacks JOHNAR 20/2 22 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE N/ALEVINDALE HEBREW HOME If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 □ M 2 💢 F MD 90 Director 215-22-8288 Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10b. County r 28a-f show notified at show 1 X Yes 2 □ No Director BALTIMORE MD N/A 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number "natural", or Items 23a or USA 21215 BELVEDERE AVENUE, 2434 W. #156 by Funeral Pages 1 and 2 should be filed within 72 hours after death 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🏋 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: WHITE 1 ☐ Yes 2 🛣 No Baltimore, Maryland 21215-0036 3 X Widowed 4 ☐ Divorced Year or Dates: er than "natura the Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) al Hygiene. other than HOMEMAKER OWN HOME 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Is marked MICHELSON FANNIE **GERSON** traumatic 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2:3 Department of Health an Important: If Item 27 Is any Injury or other trau once. OWINGS MILLS, MD 21117 12131 FAULKNER DRIVE, BRIAN SACKS/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 01/23/2012 ROSEDALE, MD 4 Donation 5 Other (Specify) FORBAND CEMETERY 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Euneral Service Licensee 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part1. Enter the efsease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failede. List only one cause on each line. Immediate Cause (Final **Physician** resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year Month in the past 12 months? 4☐Pregnant at time of death ☐Yes 2☐No 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 □ No 2 X No 1 TYes I or Attending Physician: after death.
Director: After this certifica 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: Hospital: 1 ☐ Yes 2X No 1 🗌 Inpatient 2 ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To funeral 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28b. Time of (Month, Day Year) Injury 1 🔀 Natural 5 Pendina 1 ☐ Yes 2 ☐ No investigation 2 Accident in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier 29c. License number 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) homas Baltimore, MD Levindale Hebrew Home 31. Date filed (Month, Day, Year)

JAN 2 5 2012 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

			State of Mary		artment of He tificate of De			201	2 01585	
			1. Decedent's Name (First, Middle, Last)	Cer	lilicate of De	Jaur	2. Date of Death	3	3. Time of Death	
М	Physicia	n/	PEARL SEIDLER					20, 2012 Year		
J. 2.	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or L			4c. County of Dea		
-	LACITITE .	·.	MILFORD MANOR		BALTI	MORE		BALTI	MORE	
	Funeral Director		5. Social Security Number 215-16-2356 Usual Residence of Decedent 6. Sex 1 □ M 2 ☒ F	yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 03/24/19	Year) C	irthplace (State or Foreign ountry) MD	
	show	'n		c. City, Town or Lo	cation				10d. Inside City Limits	
	Maryla 8a-f	Director	MD N/A	BA	LTIMORE				1X Yes 2 □ No	
	a or see		10e. Street and Number		10f. Zip Code		1	0g. Citizen of What C		
	th with ms 23 must	Funeral	6317 PARK HEIGHTS AVE., #3		2121 Was Decedent of Hist		cify Version No.	US 14. Race - Am		
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 □ Never Married 2 ▼ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever Armed Forces? 1 □ Yes 2 ▼ No If Yes, Give Year or Dates.	I	f Yes, specify Cuban,	, Mexican, Puerto I	Rican, etc.)	Black, Wh	ite, etc.	
2-0	hour hatu dical	plete	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occupat	tion tring most of working	ng I	16b. Kind of Busines	s/Industry	
2	hin 72 ne. than ' le Me	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	life. D	O NOT use retired)			OWN HO	IME	
7	Hygiel Hygiel Ither	Be C	12 17. Father's Name (First, Middle, Last)	I HC	MEMAKER	18. Mother's Name	(First, Middle, N		ME	
lan	be file ental ked c	으	JOSEPH LEWIS		1	VIRGIN		DRAPER		
Maryland	nould and Mi s mar umat		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street an	nd Number or Rura	l Route Number,	City or Town, State, 2	Zip Code)	
Σ	id 2 si salth a n 27 i er tra		AARON SEIDLER / HUSBAND	6317	PARK HEIG	HTS AVE.	, #304		E, MD 21215	
ore	of He of He if item		1 X Burial 2 Cremation 3 Bemoval from State		natory or other place,)	Date	20c. Location - City	or Town, State	
ij	. Pag tment tant: jury o		4 Donation 5 Other (Specify)		CHIZUK AM			BALTIMORE		
Baltimore,	permit Depart Impor any in once.		21. Signature of Fungral Service Licensee	100	2. Name and Address 200 REISTE			SON & BROS KESVILLE,		
			23a. Part 1. Enter the disease, or complications that caused the	e death. Do not ente	er the mode of dying,	, such as cardiac o	r respiratory arre	est,	Approximate Interval Between	
,20	hydrauv	V 5	Immediate Cause (Final disease or condition	herme!	2 //c m	contra			Onset and Death	
	Medical Examiner		resulting in death) a. Du to (or as a co	onsequence of):						
	LXammo	Į.	Sequentially list conditions, b. Due to (or as a co	oppositioned off.						
	ed nsit	Examiner	if any, leading to immediate Due to (or as a concase. Enter Unidenying Cause (Disease or Injury	orisequerice oi).						
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09	ate be executed hysician and the burial-transit	dical	d							
9289	ificate ig phy as the	Med	IF FEMALE:							
Box 6	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Me	23c. If yes, outcome of	Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)	1		23d. Date of delivery Month Day Ye		
ls, P.O.	uires that the signed by ald be detained	ed by Pr	Part II. Other significant conditions contributing to death but	not resulting in the t	underlying cause give	en in Part I.	23e. Did to		to the cause of death? Probably 4 □ Unknown	
Records,	sician: The law req s certificate has bee lirector, page 2 sho	Somplet		24a. Was a autop perfor 1 Yes	sy prior t med? death	autopsy findings available to completion of cause of ? Yes 2 I No				
a	sian:]	Be	25. Was case referred to medical examiner?			ice of Death (Checi	k only one)			
of Vital	hysic this ce al dire	은	1 ☐ Yes 2 ☐ No Hospital:	2 ER/Outpatie		4 Nursing Ho		ence 6 Other (Sp	ecify)	
οι	ling P	ate:	27. Manne of Death 1	/ear) 28b. Time o	work?	at ? Yes 2 □ No	28d. Describe ho	ow injury occurred		
Division	or Attendatter death	Certific	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury building, etc. (9	28f. Location (S City or Town	treet and Number or n, State)	Rural Route Number,				
۵	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical Certificate:	29a. Certifier (Check conly one) 1 Certifying Physician: To the best of my Medical Examiner: On the basis of examiner: On the basis of examiners of the basis of	mination and/or inves	stigation in my opinio	 n. death occurred a 	t the time, date ar	nd place, and due to th	ne cause(s) and manner stated	
2	To the within To the compl	2	only one) 3 Li Certifying Nurse Practitioner: To the bearing Survey Signature and title of certifies Survey	- M.D	29c. License					
1			30. Name and address of person who completed cause of dea	th (Item 23a) (Type,	Print) - + No	al /	(Geso	1/k, mai	2 % 2012 - + ball - 208	
	Sta Registi		31. Date filed (Month, Day, Year) JAN 2 5 2012 Summ S.	Signature						

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 11 per inf. 6923 1/31/12 dk State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) Month 7:10 am Physician/ anilary Medical not institution, give street and 4c. County of Death Examiner POH N/AIf Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 216-42-6089 Months Hours 1**x** M 2 □ F **Director** Yrs 68 03/23/1943 Maryland 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State Director 1 K Yes 2 No MD N/ABaltimore 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code or items 23a or Funeral U.S.A. 5529 Cadillac Ave. 21207 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Known as Janes Russell Baltimore, Maryland 21215-0036 Black, White, etc þ 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: Black Completed 3 Widowed 4 Diverged 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b.Kind of Business/Industry Baltimore City Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me 4 years Elementary/Secondary (0-12) Police Dept. Police Officer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ John R. Sparks Olivia Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James R. Sparks Jr. (son) 5722 Plainfield Ave., Baltimore, MD21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Eurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) King Mem Park Cem01/28/12 Baltimore, MD Joseph Addes of Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, 21. Signature of Funeral Service Licenses PA MD21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) FARCTIOL **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examir burial-transit Cause (Disease or injury that initiated events resulting in death) Last and attending physician Physician/Medical The law requires that the death certificate be P.O. Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Other (specify) Pregnant at time of death the 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page 2 death? perform To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate is 1 Yes 2 No Yes filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No ျှ 1 Yes NOutpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Ma er of Death 28b. Time of Certificate: 28d. Describe how injury occurred injury Natural 5 \square Pending Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Cartifying Nurse Fractitioner To the Cart of my knowledge, of the course of the time, and any large and due to the cause(s) and manner stated. completely 29b. Signature and title of certifier State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death dent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death 6:28 PM Physician/ Month ucker Jan 20 2 Medical Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner Secours allimor Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 🗆 M 2 🗹 F Days Months Hours Min. Yrs Director 28a-f shov 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked outher than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director ti more 1 Yes 2 No 10f. Zip Code 10e. Street and Number. 10g. Citizen of What Country? Funeral 21223 150M 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital-Status 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married ğ 2 100 ☐ Yes Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify 3 Widowed 4 Divorced Completed laci 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retiled) /Seconday (0-12) College (1-4 or 5+) stodian Be 17. Father's Name (First, Middle, 18. Mother's Name ည Informant's Name/Relationship (Type Sister siendse Place of Disposition (Na cemetery, crematory or City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the dilease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart in livre. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ pukemia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): physician Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 use as the 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for 5 Other (specify) Month Day Year Pregnant at time of death been signed by the s should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? anemia Records, 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy certificate Yes 25. Was case referred to medical examiner? Be Division of Vital the funeral director, 26. Place of Death (Check only one) Hospital: Other: ျ 1 Tyes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes Certificate: 28d. Describe how injury occurred After iniury Natural 5 Pending To the Hospital or Attendii within 24 hours after death. To the Funeral Director, A 2 No Investigation 2 Accident
3 Suicide
4 Homicide Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title or certifier 29d. Date signed (Month, Day, Year) 2012 066267 San 21

State Registrar DHMH 17 Rev 7/2009 lame and address of person who completed cause of death (Item 23a) (Type, Print) 2000

32. Registrar's Signature

abatabai

31. Date filed (Month, Day, Year)

JAN 2 5 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JANUARY 21 2012 Kenneth Tilghman 11:12 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death GREATER BALTIMORE MEDICAL BALTIMORE TOWSON If Under 1 If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Min (Month, Day, Year) Hours 1 M 2 □ F **Director** 215-92-0626 MD Apr 23, 1962 Usual Residence of Decede Fshow or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD **Baltimore** 1 Yes 2 No **Baltimore City** 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be Funeral 21218 1504 Upshire Road U.S.A. Kennett 12, Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 🙀 Married TIGH naw, Kenne Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: **Black** Specify: Completed 3 - Widowed 4 - Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) should be filed with h and Mental Hygien 7 is marked other tl Maintenance Apartment Building Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Blonde Hood Melvin Tilghman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is 1504 Upshire Road Baltimore, MD 21218 Tammy Tilghman 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Feb 01, 2012 Lansdowne, Maryland Mt. Zion Cemetery 21. Signature of Fundal Service I, cen 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part 1. Enter the disease shock, or leart failure. Li omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Examiner ACIDOSIS FTABOLIC Source thally liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine ONCIESTIVE Hospital or Attending Physician: The law requires that the death certificate be executed nding physician and use as the burial-trans Physician/Medical RNIOMYOPATH Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ō in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death ed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò REMAL Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed MELCITUS. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has l autopsy performed? certificate 2 🗌 No 1 Tyes Division of Vital 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 \square Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 □ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) oma & CD 02060887 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD CIZEATER RAITIMORE MEDICAL CENTER omas

Registrar

State

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend 17, per fth, 9924, 2-21-12 sm.
State of Maryland Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ Month Lois M. Turpin 11:25 AM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore N/A St. Agnes hospital 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min (Month, Day, 1 M 2 X F 220-38-5743 72 Yrs **Director** Md Dec 9, 1939 Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Director 1 X Yes 2 No MD **Baltimore City Baltimore** 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral items 23a 4524 Pen Lucy Road 21229 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Black Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) **Retail Store** Retail 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edmond Burrell ဂ္ Edward Burrell Louise Allen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angela Cornish 5121 Greenwich Avenue Baltimore, MD 21229 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Brooklyn Park, Md. 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery & Jan 24, 2012 22. Name and Address of Facility

Estep Brothers Funeral Service, P. A.
1300 Eutaw Place Baltimore, Md 21217 21. Signature of Funeral Service Licenses 23a. Part 1. 5 fer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition [≒]Ph_sician/ Pheumonia **Medical** resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or ilrijury as the burial-transi that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 signed by the attendir d be detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed? 1 Yes 25. Was case referred to medical completed filled ir by the funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No ည 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🔾 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

Registrar

State

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

handra

Shres tha

32. Registra/s Sign

urpin, Lois

900

29c. License number

S. Caton

29d. Date signed (Month. Day, Year)

MD 21229

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#20a-c,22perFH,G924,2/8/2012,WS
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10:08 P M 2012 Gertrude Elizabeth Valentine January Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore 1101 N. Central Avenue If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday **Funeral** Days Nov 17ay, Yerr944 Virginia 227-58-4520 67 **Director** 1 □ M 2 1 F ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 X Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21205 USA 1101 N. Central Ave. "natural", or items edical Examiner mu be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces 7 1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race = American Indian Black, White, etc. 1 Never Married 2 ☐ Married Completed by 1 Yes Maryland 21215-0036 Specify: black 1 ☐ Yes 2 X No Specify: 3 Divorced 4 Divorced Year or Dates. Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene. 27 is marked other than ' traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) 12 0 correctional officer penal system Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lorenzo Valentine Margaret Elizabeth Chatman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other tran Katrina Wilkes - niece 1808 Monteiro St; Richmond, VA 23222 Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 cemetery, crematory or other place) 4 ☐ Donation 5 📉 Other (Specify) in State Atlantic Crem. 2-5-2012 Glen Burnie, MD Funeral Servi Simplicity Cremation and Funeral Services 7090 Ridge Rd Hanover, BD 21076, MB 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest wheart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ ar common disease or condition Medical resulting in death) 0 **Examiner** SIM Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as consequence of) burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or physician s the burial Physician/Medical Records, P.O. Box 68760 as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death q Unknown 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed sate has page 2 s 1 Yes 2 No Yes 2-Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: ၉ 1 Inpatient 2 ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After to completely filled in by the funer Natural 5 Pending 1 Yes 2 No M Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 0 (Type, Print) 30. Name and address of person who completed cause of death (Item 23a) 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ George Vlahos January 19, 2012 12:10 P.M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Anne Arundel Linthicum Tate Hospice House Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** New York Days Min. 1 🛛 M 2 🗆 F Months Hours 93 1272071918 Director 071 16 0240 Usual Residence of Decedent 23a or 28a-f show 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If fiem 27 is anarked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🎛 No Linthicum Marvland Anne Arundel 10e. Street and Numbe 10g. Citizen of What Country? 10f. Zip Code Funeral 21090 710 E. Maple Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White If Yes Give 1 Yes 2 X No Specify: 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Manager Restaurant 6th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Vlahos Demetria Rigas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
417 Music Lane Linthicum, Maryland 21090 Demetra Bowers / Daughter 417 Music Lane 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 01/24/2012 Baltimore, Maryland Greek Orthodox Cem. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, manuscel Baltimore, Maryland 21225 ecome 4001 Ritchie Highway 23a. Part 1. Enter the diseas or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final set and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or iinjury death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes ∠ □ 9 ☐ Unknown by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗌 No 1 Tes Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director. After this certific completed filled in by the funeral director, Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) HOSPICE 2 Other: 1 Yes ည 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury work? Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Registrar

AFULLBATEL 4600 RITONI

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ The 1 ma Voelker 11:30P [™] January 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Baltimore Gilchrist Towson Social Security Number 8. Date of Birth (Month, Pay Yea April 7, If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign Days 1 🗆 M 2 🗶 F Hours 217-34-4171 Maryland Director 73 1938 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD. Baltimore Towson 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 103 Kenilworth Park Dr. #3A USA 21204 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 2 **X** No 1 Never Married 2 X Married Completed by 1 Yes If Yes, Give 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", 3 Divorced Specify: White Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 7 th and Mental Hygiene. than Elementary/Seconday (0-12) College (1-4 or 5+) Banking & Investments Senior Vice President Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Emma Bennett George Lennox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Towson, MD. 21204 1 and 2 sof Health Bernard Voelker/ Husband 103 Kenilworth Park Dr. #3A 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 X Cremation 3 Removal from State etery, crematory or other p Hilltop Service Co. 1-25-12 Towson, MD. 4 ☐ Donatjon 5 ☐ Other (Specify) 22. Name and Address of Familia Wson Funeral Home, 21. Signatur of Funeral Service Lipp see 1050 York Rd. Towson, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final merodonal concer of Physician/ disease or condition resulting in death) MUXCH Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, inspiring to immediate Due to or as a consequence of cause. Enter Underlying Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the Innerial director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) Was pile 1 Tyes ၉ 2 No ER/Outpatient 3 DOA 1 Inpatient 2 I Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 2 Natural 5 Pending work 1 Tes 2 🗌 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated d title of certifier 29b. Signature 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ·KD hanks 6701 N. <u>MM</u> 32. Registrar's Signature State Registrar

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		partment of Health and Mental Hygiene ertificate of Death Reg. No	2012 01591				
Physician /Medical	1. Decedent's Name (First, Middle, Last) MARY WYNN 4a. Facility Name (If not institution, give street and number)	2. Date of Death Month Da JANUARY 2 4b. City, Town, or Location of Death 4c	y Year 3. Time of Death 12: 26 PM Coupty of Death				
Examiner Funeral	Johns Hopkins Bayview Medical Center 5. Social Security Number 6. Sex 1 M 2 F F 7. Age (In yrs. last birthdo	Months Days Hours Min. Alvioniti, Day, real)	9. Birthplace (State or Foreign				
Show show dat	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or		10d. Inside City Limits 1 □ Yes 2 🖽 No				
permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	10e. Street and Number 118 Chestnut St.	21222	tizen of What Country? U.S.A 14. Race - American Indian,				
thin 72 hours after dee e. Medical Examiner m mpleted by Fune	3 Widowed 4 □ Divorced If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 No Specify:	Black, White, etc. Specify: Black				
filed within 72 hou Hygiene. Hygiene. than "natura int, the Medical E Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	live kind of work done during most of working le. DO NOT use retired) Clerical Asst.	Insurance				
d 2 should be file th and Mental Hy 27 is marked othe traumatic event,	Loud Page	18. Mother's Name (First, Middle, Maide Marsho Mailing Address (Street and Number or Rural Route Number, City	4/				
Pages 1 and 2 s nent of Health ar ant: If item 27 Is ary or other trau	1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	isposition (Name of crematory or other place) Date Date 200. L R	Ne ud 21208 ocation - City or Town, State				
permit. Pages 1 a Department of He Important: If item any Injury or othe	4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	22. Name and Add ss of Facility Car H C. Dony Funer of 1701 Accurd St. Balb.	Service P.A. Ud. 21217				
Physician	23a. Fart : Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of)	TERY DISEASE	Approximate Interval Between Onset and Death				
Examiner	b de la companya de l		6 YEARS				
cate be executed physician and s the burial-transit edical Examii		:					
certifica nding ph use as 1	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of delivery Month Day Year				
aw requires that the death is been signed by the atter 2 should be detached for pleted by Physicis	Part II. Other significant conditions contributing to death but not resulting in	310 3112011) 111g 00000 g. 1011 1111 1111 1111 1111	o use contribute to the cause of death? 2 ☑ No 3 ☐ Probably 4 ☐ Unknow				
The law ate has by page 2 s		24a. Was an autopsy performed? 1 Yes 2 15 1	24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No				
ing Physician: Th. After this certificate funeral director, pa	examiner? 1 ☐ Yes 2 🛣 No Hospital: 1 🛣 Inpatient 2 ☐ ER/Outp	26. Place of Death (Check only one) atient 3 □ DOA Other: 4 □ Nursing Home 5 □ Residence					
ding h. After fune tion		Natural 5 Pending investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural R					
		death occurred at the time, date and place, and due to the cause for investigation, in my opinion, death occurred at the time, date	o(s) and manner as stated. and place, and due to the cause(s)				
To the Hospi within 24 hou To the Funer completely fil	one) and manner stated. 29b. Signature and title of certifier // MD	29c. License number 29d. I	Date signed (Month, Day, Year)				
61	30. Name and address of person who completed cause of death (Item 23a) (1	Type, Print) 4940 Eastern Aven	ue, Baltimore, MD, 2122				
State Registrar	31. Date filed (Month, Day, Year) JAN 2 5 2012 32. Red Star's Signature	parke					

DHMH 17 Rev 1/2001 11595

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Baltimore Northwest Hospice at Northwest Hospi Randallstown Social Security Number If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Min. 216 24 0072 Hours 1 🗌 M 2 ื F Director 82 06/08/1929 Maryland Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Reisterstown Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with 304 Wembley Road 21136 U.S. within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify. White 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumation. Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Frederick Sullivan Hazel Cameron 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Rhoades / Daughter 304 Wembley Road Reisterstown, Maryland 21136 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 X Burial 2 \square Cremation 3 \square Removal from State 01/24/2012 Cedar Hill Cemetery Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licer 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause or Immediate Cause (Final Ph. sician/ disease or condition resulting in death) umon19 Medical (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Inderlying Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) ____ ò in the past 12 months? Day Month Year Pregnant at time of death Yes 2 No ed by the a 9 Unknown 9 Unknown P.O. been signed by should be detac contributing to death but not resulting in the underlying cause given In Part I. 26e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s this certificate has autopsy 200 No Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 **N**o Hospital Other: 은 1 Inpatient 2 I 4 Nursing Home 5 Residence Other To the Hospital or Attending Physical 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral director. ER/Outpatient 3 DOA 27. Manner of De-th 28a. Date of injury (Month, Day, Year) 1 Natural 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred injury 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occur urred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of and address of person who completed cause of death (Item 23a) 31. Date filed (Month, Day, Year) State

Registrar

12-00488 Donald Watson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2012 01596 State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		Cert	ificate of	Death		,,,,	Reg.	No.		
Physici		1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year							Time of Death			
Medical Exami	Examiner Donald R. Watson, Jr. January 18, 2012								0209 hrs			
			-		4		r Location of	f Death		4c. County of	Death	
		Harbor Hospital Center				Baltimore	- Leu-	0411 10	Data of District	N/A	O. Disther	1
Funeral Director			1	e (In yrs. las	st birthday)	If Under 1 Ye Months Da		Min		MM/DD/YYYY)	9. Birthp Foreign	lace (State or
Director		120 00 0001	1 X M 2 F	37	Yrs.		,]	L2/27/	1974	Count	ry) MD
'n		Usual Residence of Decedent		10c City T	Fown or Locati	on		_			1/	Od. Inside City Limits
ow any									Yes 2 No			
Maryland 28a-f show d at once.	tor	MD N	/ A	Ba	ltimo	re 10f. Zip Code			Lion	. Citizen of Wha		
Mar r 28s	Director	ice. Street and Number				101. Zip Code			109	. Citizen or vvna	at Country	
with the Maryland ns 23a or 28a-f sho be notified at once		4100 Marib				212				USA		
ath wi	Funeral	11. Marital Status 1 Never Married 2 Marr	12. Was Decedent Armed Forces?			s Decedent of H es, specify Cuba				14. Race - White,		n Indian, Black,
er dez	Fu		1 Yes 2	No	1	Yes 2 N	a anorifi:			Specific	D1 -	-1-
5-0036 led within 72 hours afte Hygiene. I other than "natural", the Medical Examiner	by	15. Decedent's Education (Specif	or Dates:	npleted)		t's Usual Occupa		ind of work	done 1	Specify: 6b. Kind of Bus	Bla iness/Indi	
2 hou	Completed	Elementary/Secondary (0-12)	College (1-4 or 5			ost of working lif						,
than than edica	du	12			Self	Emplo	ved			Consti	cuct	ion
ed wi	S	17. Father's Name (First, Middle, L	ast)					s Name (Fir	st, Middle, Ma	iden Surname)	uot	
21215-0036 21215-0036 Mental Hygiene. marked other that	B,	. Donald R. Wa	atson, Sr				She	erry	Imes			
ID 21215-0036 strongly be filed within 72 hours and Mental Hygiene. 77 is marked other than "natur nattic event, the Medical Exam	2	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailing	Address (Stre	et and Numb	ber or Rura	Route Number	er, City or Town	, State, Zi	p Code)
nore, MD 21215-0036 ages I and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. nt: If item 27 is marked other than "natural", or items 23a or 28a-f aho other traumatic event, the Medical Examiner must be notified at once		Donald R. Wa	tson, Sr.	- 1	2608	Hollin	s Fei	rry F	<u>Rd., B</u>	altimo	ore,	Md21230 wn, State
FHear Te		20a. Method of Disposition 1 XXBurial 2 Cremation	3 Pemoval from St		ace of Disposi ematory or oth	ition (Name of co ner place)	emetery,	Da	ate 2	20c. Location - 6	City or To	wn, State
Baltimore, permit. Pages lar Department of Hee Important: If itel njury or other tr		4 Donation 5 Other Spec		10	-	on Cen	n.	1/27	/2012	Lansd	owne	, Md.
Baltimo permit. Page Department of Important: injury or otd	1	21. Signature of Funeral/Service Li			2 2 N	ame and Address						
		Clell	DUS		13	00 Eut	aw Pl	lace,	, Balt	imore.	$_{\rm Md}$.21217
Physician		23a. Part I. Enter the disease, or co failure. List only one cause or		the death. [Do not enter th	e mode of dying	, such as ca	rdiac or res	spiratory arrest	, shock, or hea	rt ,	Approximate Interval Between Onset and
/Medical		Immediate Cause (Final disease	a. Acute Pancreati	tis								Death
.Adminici		or condition resulting in death)	Due to (or as a conse	quence of):	:	,						
	_	Sequentially list conditions,	b.									
	Examiner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conse	equence or):								
=	хап	(Discass or injury that initiated events resulting in death) Last	Due to (or as a conse	quence of):								
ecuted and trans	I		d									
760, icate be executed physician and the burial - transit	Medica	UNPENDED	AMENDED									
760, icate be physic the bur		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcon	ne of pregna						23d. Date of c		
eath certifi attending for use as r	iä	past 12 months?	1 Live birth 2 Pregnant at	time of deat	th =		Ectopic	pregnancy		Month	Day	Year
Box 68's death certification attending	Physician	1 Yes 2 No 9 Unkno			otr ⊃ Utr	ner (Specify)						
O. Bo it the de by the ached f		Part II. Other significant condition	ns contributing to death	but not res	sulting in the u	nderlying cause	given in Par	t I.	23e. Did toba	cco use contrib	ute to the	cause of death?
ires that the signed by the detached	ğ								1 Yes	2 No 3	Probab	ly 4 🗹 Unknown
ords, w requir is been s	Completed				<u>-</u>	,		_	24a. Was an			sy findings available
COT law : has t	ğ								autopsy performe	ed? de	eath?	pletion of cause of
tal Records, tian: The law require certificate has been si	S	25.11							1 ✓ Yes 2	No1 {	✓ Yes	2 No
Vital Rec ysician: The l his certificate I	å	25. Was case referred to medical examiner?	Hospital:	-	TD/O		e of Death (0			esidence 6	104	
Division of Vital in or Attending Physician rs after death. al Director: After this certiced in by the funeral director.	욘	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Inju		R/Outpatient 28b. Time of Ir		ury at Work?			w injury occurre		
nding Ph Ith.: After t e funeral	5	1 ✓ Natural 5 Pendin	(Month, Day,Ye	ear)		· · I _ ·	Yes 2	- 1		, , .		
Sibor Attender r death ector: by the	g	2 Accident Investig	gation 28e Place of Ini	urv - At hon	ne farm stree				Location (Stre	eet and Number	or Rural	Route Number, City
S affe	Certification:	3 Suicide 6 Could r	not be	ary 7 minor	,,	i, raciory, cinco	bunding, oto		or Town, Stat		or rear ar	rtodio rtambor, ony
Cospie t hour uner		4 Homicide 29a. Certifular Phys	sician: To the best of my	knowledge	death occur	and at the time.	tate and place	e and due	to the cause/	e) and manner	ac etated	
Division of Vital Records, P.O. Box 68760, To the Etopital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans.	Medical	Torreon oray	ner:On the basis of exam	_								ause(s)
To wit	ĕ	29b. Signature and title of certifier	and manner stated.			29c, Licen	se number		2	9d. Date signe	d (Month,	Day, Year)
_		Can de A	LADDAIN			O.C	M.E.			January 18,	2012	
Pour	ŀ	30. Name and address of person w	ho completed cause of d	eath (Item 2	(3a)							
70			stant Medical Exan			imore Street	, Baltimoi	re, MD 2	1223			
St	ate	31. Date file (Month, Day Ger)	32. Registra	s Signature	uked							
Regist		PAGE M O COLF	berown &	17								

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 2 1 - For State Registrar Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Deat Physician/ WEINBE NNA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE SEASONS HOSPICE @ NORTHWEST HOSPITAL RANDALLSTOWN Birthplace (State or Foreign Country) 8. Date of Birth 6. Sex 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year) Hours Min. Director 213-38-7860 1 🗆 M 2 🗶 F 85 03/30/1926 GERMANY Usual Residence of Deceden 28a-f show ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 X No BALTIMORE PIKESVILLE MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 398 MT WILSON LANE 21208 items death 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Examiner Yes, specify Cuban, Mexican, Puerto Rican, etc. o by 1 Never Married 2 Married Yes 2 X No 3altimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: "natural" Completed 3 X Widowed 4 Divorced WHITE Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the EDUCATION TEACHER of Health and Mental Hygitem 27 is marked othe other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ RUDERMAN KRAMER FANNIE **JACOB** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 421 YESHIVA LANE, #1C, PIKESVILLE, MD 21208 AVIVA WEISBORD/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
ANSHE EMUNAH
ATTZ CHAIM CONG 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/24/2012 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Lice 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Ph. sician/ disease or condition Medical resulting in death) as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence or): the burial-transit and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical fo the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death ed by the at detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy has 1 Yes 2 No 25. Was case referred to medical 26 Place of Death (Check only one) To Be examiner? Other: 4 Nursing Home 5 Residence 2 **N**O 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA hours after death. Ineral Director: After this 28a. Date of injury (Month, Day, Year) Medical Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred iniury 1 Natural 5 Pending Investigation Accident Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely within 2. only one) 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Ripe, Print) 32. Registrar's Signatu State Registrar

DHMH 17 Rev 06-2011

12-00434 Devon Williams amend #1,per me,g931 9-5-12 sm

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 20 | 2 | 0 | 5 9 8

		1- For State Registrar			cate of D			ygione Re	Z U 1 Z g. No.	_ 0100
Physici ledical Exam		Decedent's Name (First, Middle,Last	evon Josh	liams ua WII	iams J	Itiams		Date of Death Month January 15	Day Year	3. Time of Death 1610 hrs
		4a. Facility Name (if not institution, give Sinai Hospital	street and number)			city, Town, or Location altimore	of Death		4c. County of Death	
Funeral Director		5. Social Security Number 6. Set 2 16-89-0134 1		(In yrs. last b		Under 1 Year If Under 1 Year I	er 24Hrs s Min.	_	(MM/DD/YYYY) 9. Bird Foreig Con	
riand -f show any once,	tor	10a. State 10b. County 10c. City, Town or Location								10d. Inside City Limits 1 Yes 2 No
h the Mary 3a or 28a otified at	I Director	10e. Street and Number	Drive.	#20	10	f. Zip Code) 15	109	g. Citizen of What Cour	ntry?
215-0036 and Hygien after death with the Maryland at Hygien that Hygien than "natural", or items 23a or 28a-fab. ent, the Medical Examiner must be notified at once	by Funeral		If Yes, Give Yeer or Dates:	√ No	If Yes, s	cedent of Hispanic Original Control of the Control	n, Puerto		14. Race - Americ White, etc.	can Indian, Black,
5-0036 led within 72 hours Hygiene. other than "natur	Completed I	15. Decedent's Education (Specify onl Elementary/Secondary (0-12)	y highest grade comp College (1-4 or 5-		during most o	sual Occupation (Give f working life. DO NOT			16b, Kind of Business/li	ndustry
21215-0036 Juld be filed within 7 Mental Hygiene, marked other than	Be	17. Father's Name (First, Middle, Last)	lilliam	5	Sr.	18.Mother	131	(First, Middle, Ma	Weste	
MD and 2 sho salth and 2 is 27 is raumati	2	19a. Informant's Name/Relationship (Ty NS Darlein 20a. Method of Disposition	pe, Print)	11	0600	_	nber or R	#201	Ba.H.	MORIAIS
		1 Burial 2 Cremation 3 4 Donation 5 Other Specify: 21. Sign or of Funeral Service I cens			atory or other p	ocial Park	: إل	23/12	20c. Location - City or	ca. Mb
	l V	23a. Part I. Enter the disease, or compli	Mayria.	K. M.	203		Puis:	S Funer Ave f	301tz. Mi	0 21216
Physician /Medical Examiner		failure. List only one cause on eac Immediate Cause (Final disease a	h line. Dxycodone ue to (or as a conseq	Intoxi		oue or dying, such as c	al Glac Oi	respiratory arres	st, Shock, of fleat	Approximate Interval Between Onset and Death
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760, icate be executed g physician and the burial - transit	Medical E	d. X UNPENDED	AMENDED 1,23	Ba,27,2	28a-f,p	er me,g927	5-1	8-12 sm		
Box 68760, e death certificate by the attending physic ed for use as the but		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth 4 Pregnant at til	of pregnancy		eath 3 Ectopic	c pregnar		23d. Date of delivery Month D	ay Year
m S E B	~ 1	Part II. Other significant conditions	9 Unknown	out not resultin	ng in the under	lying cause given in Pa	art I.	23e. Did tob	acco use contribute to t	he cause of death?
cords, P.O. law requires that the has been signed by 2 should be detach	eted by				-			1 Yes 24a. Was an	2 No 3 Prob	ably 4 Unknown opsy findings available
Division of Vital Records, rat or Attending Physician: The law requirers after death. al Director: After this certificate has been si led in by the funeral director, page 2 should be	Completed	25. Was case referred to medical				26.Place of Death	(Chack o	autopsy perform	ed? death?	ompletion of cause of
Vita hysician this cer	10 Be	overines?	spital: 1 Inpatient	2 🗸 ER/0	Outpatient 3	1Other 5	,-		esidence 6 Other:	
On of Vi		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day, Yea fd 1-15-		Time of Injury d 3:35 p	28c. Injury at Work			w injury occurred ingetsed d	rugs
Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that th within 24 hours after death. To the Fuoeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detach	Certification:	2 X Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injui		arm, street, fac	tory, office building, etc		or Town, Sta	reet and Number or Rur te) 6600 Eber imore, MD.	al Route Number, City 1e Dr. Apt
Divis To the Hospital or A within 24 hours after To the Fuoeral Dire completely filled in b	Medical (one) 2 Medical Examiner:							(s) and manner as state and place, and due to the	
E * E 3	Me	29b. Signature and title of certifier	- 5) lob b	120	50	29c. License number O.C.M.E.			29d Date signed (Mon	
		30. Name and address of person who co Victor Weedn MD JD Ass	mpleted cause of deasistant Medical E	,	900 W. Ba	altimore Street, Ba	altimor	e, MD 21223	3	-
St. Regist	_	31. Date filed (Month, Day, Year) JAN 2 5 2012	32. Registrar's	Signature						
DHMH 17 Rev 1/20		/	were ,	OF	RIGINAL					

For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month YATOVITZ RHONA LEE Danuary 2012 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Sincer N/A 8. Date of Birth (Month, Day, Year) er 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** If Und Months 214-22-2803 **Director** 1 🗆 M 2 🗶 F 84 03/19/1927 MD show 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland b. County
N/A must be notified at Director 1 X Yes 2 X 140 28a-f MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a 6605 EDENVALE ROAD 21209 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian other traumatic event, the Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ģ If Yes, Give Year or Dates ☐ Yes 2 X No Specify: Specify: Completed 3 X Widowed 4 Divorced WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fisherships is marked of ge 1 and 2 should be fil nt of Health and Mental : If item 27 is marked မ AARON EISENBERG **JEAN** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SANDY MASTERS / DAUGHTER 310 LEYTON ROAD, REISTERSTOWN, MD 21136 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Page 1 Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 01/23/2012 BALTIMORE, MD BNAI ISRAEL CONG. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine n any, leading to immediate cause. Enter Underlying Cause (Disease or injury burial-transi and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical as the l IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ate has been signed by the atter page 2 should be detached for u in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by fibrillation Division of Vital Records, No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy perform death? within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. I I or Attending Physician: Taffer death.
Director: After this certifice 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death Certificate: 28d. Describe how injury occurred 28c. Injury at Natural (Month, Day, Year) 5 Pending injury work?
1 Yes 2 No 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated could be a stated of the cause (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SINTI OF IFTIG20H 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 5 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#10b, 10d, perFH, G923, 1/25/2012, WS

State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 Year Francis Arthur Adams 8:20 P M January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Charlotte Hall Veterans Home Charlotte Hall Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex Age (In yrs. last birthday) 8 Date of Birth Funeral 08/23/1920 1 **X X**M 2 \square F Hours 224-07-4687 91 Virginia Director Usual Residence of Decedent or 28a-f show notified at within 72 hours after death with the Maryland 10a State 10b. County 10c City Town or Location 10d. Inside City Limits Director Maryland St. Mary's Charlotte Hall 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or idical Examiner must be Funeral 29449 Charlotte Hall Road 20622 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black. White, etc. 1 Never Married 2 X Married Completed by 1 x XYes 2 No 1939 If Yes, Give Year or Dates. 1945 Maryland 21215-0036 1 Yes 2x No Specify: Specify. 3 Widowed 4 Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12th Self - Employed Barber permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ George L. Emma Teivera Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nelson L. Pumphrey / Per. Rep. 5607 Kenwood Street Temple Hills, Maryland 20748 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 Burial 2 XXemation 3 Removal from State 1/5/2012 Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Kalas Crematory Signatur Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home PA 10hrs 20745 6160 Oxon Hill Rd. Oxon Hill, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ ZHEIMER disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner Due to (or as a consequence of) ed by the attending physician and detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Adams, Francis IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Year Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ESSENTIAL MYPERTENSION 1 ☐ Yes XX No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? After this certificate 2 N Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, I 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 Yes ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 I 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 2 Accident
3 Spice 1 Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical

State Registrar

JAN 05

LEENA

29a. Certifie (Check

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

RAO

KODALI 29449 Charlotte Hall Rd. Charlotte Hall, MD

Cyclifying Nurse Practioner: To the best of my knowled,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

🗠 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

DOO 67788

29d. Date signed (Month, Day, Year)

2012

20622

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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		•	State Registrar				Cer	tificate	of D	eath			Reg. No	. 201	2	_0_	60
	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Company Hillda Mangarate Small wood 7 years											ay Yea		3. Time			
3	Medi		Hilda M	largar	et Smal	llwood	Ayres					1	6	201	2	6:2	5 P ^M
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and the same	·/		Atlanti					Ber		If I la day	04 Uro I o			Worce			
- 1	Funeral Director		5. Social Security Nur 213-18-4	931	. Sex 1 □ M 2 □ _X F	7. Age (In yrs. I	ast birthday) Yrs.	If Under Months	Days	If Under Hours		3. Date of Birl (Month, Da 4/30/	192	21	Countr	ace (State y) MD	or Foreign
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	ath w	Funeral	11. Marital Status	issale		edent Ever in U.S	s. I13. V			panic Orie	ain? (Specif	fy Yes or No-		14. Race - Ar	nerica	n Indian.	
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N 106 IQOIQ Baltimore, Maryl	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation \$			pt.	Paul	. Name an						erlin,			
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₹ 8	eath certifica attending p	J/N	IF FEMALE: 23b. Was decedent p	regnant	23c. If yes, or	utcome of pregna	ancy] r						23d. Date of	delive	y	
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0.69 P.O.	at the dead by the adetached		Part II. Other signific	cant condition	s contributing to	death but not res	sulting in the u	nderlying o	ause give	en in Part	I.	23e. Did t	obacco	use contribute	to the	cause of	f death?
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(San vision	r Atten er deal rector: by the	Certificate:	3 Suicide 4 Homicide	6 Could no	ot be 28e. Plac	ce of Injury - At he	ome, farm, stre		office		28	3f. Location (nd Number or	Rural		mber,
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\triangleleft	To the Hospital or Attending Physwithin 24 hours after death. Within 24 hours after death. To the Funeral Director: After this completed filled in by the funeral directions.	Medical	29a. Certifier 12 (Check 2 conly one) 3	■ Certifying I ■ Medical Ex ■ Certifying I	'hysician : To the aminer: On the bi lurse Practione i	best of my know asis of examinatio r: To the best of m	rledge, death o n and/or invest ly knowledge, o	occured at tigation, in r death occur	tne time, ny opinior red at the	date and n, death of time, date	piace, and ccurred at the and place,	and due to the ca and due to th	ause(s) a and plac re cause	ce, and due to the ce and manner as the ce and	ne cau as sta	se(s) and r ted.	manner stated
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JANUARY Physician/ 2012 10:50 P M SANDRA LOUISE ASHCROFT Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death **Examiner** FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK Birthplace (State or Foreign Country)
 MD 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 6. Sex **Funeral** Min. 1 🗆 M 2 🏻 F Davs Hours 0470971946 65 Director 220-42-0811 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location notified at Director 1 Yes 2 No Frederick MD Frederick 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number er than "natural", or items 23a or the Medical Examiner must be 1 Funeral 21702 IISA 1749 Carriage Way 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry 2 should be filed within 72 th and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) hotel chef Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Maude L. Stitley Archibald A. Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Heather Ridge Dr., Frederick, MD 21702 Margaret Watts/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 01/10/2012 | Frederick, MD Stauffer Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1091 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final METASTATIC WING CANCER Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner HYPERTENSION Sequentially list conditions, Examiner District for as a portrectience off if any, leading to immediate cause. Enter Underlying THRIVE Cause (Disease or iinjury that initiated events resulting in death) Last 70 the burial-transit FAILURE Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2-No Month Year Other (specify) signed by the at Id be detached fo Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has I autopsy death? perforn il or Attending Physician: after death. Director: After this certific filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No Certificate: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 Yes 2 No 1 Natural 28d Describe how injury occurred 5 Pending Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours a Hospital Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 Year) 32. Registrar's Signature 31. Date filed (Month State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🗍 01603 1 - State Registrar Amend #5 perfuneral home 1/19/20 Perfunerate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 6:15 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1886 Iverson Street Temple Hills Prince George's Secial Security Number 577 52 6912 Sex 1 M 2 □ F If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Birthpiac Country) **Funeral** (Month, Day, Year) 129/194 Months Davs Hours Min. Director 69 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director Prince George's Temple Hills MD 1 🔀 Yes 2 🗌 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1886 Iverson Street 20748 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ₺ Yes 2 □ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black. White, etc. 1 Never Married 2 X Married by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1956-57 1 ☐ Yes 2 XNo Specify: "natural", Specify: Black 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit, Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important; If item 27 is marked other t any injury or other traumatic event, the once. Bus Driver Metro 9th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Pinkey Wiley Alphonso Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thelma F.Adams/ 1886 Iverson St. Temple Hills, MD 20748 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🛛 Burial 2 🗆 Cremation 3 🗆 Removal from State GM 1/17/2012 Cheltenham, MD Veterans Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityBriscoe-Tonic Funeral Home 21. Signariy of Funeral Service Lies Millelly 2294 Old Washington Rd.Waldorf, 20601 23a. Part 1. Enter the viscouse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CANCER Physician/ UNG disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner YEARS Sequentially list conditions, dry, leading to immedia cause. Enter Underlying Cause (Disease or injury Due to for selective aduance of: Examir The law requires that the death certificate be executed and -trans that initiated events resulting in death) Last Due to (or as a consequence of): physician ar s the burial-t Physician/Medical Division of Vital Records, P.O. Box 68760 e attending p d for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Day Year signed by the a Id be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ᅙ 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed' death? 1 Yes 2 No this certificate Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No within 24 hours and wear this can be the funeral Director. After this canneleted filled in by the funeral director. မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) uma 007186 MD JANUARY 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD Mercantile Lane legistrar's Signatur Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Januar yal 10, 20 12 ar 7:33 M George Bernard Allen, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cumberland Allegany Devlin Manor If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth 6. Sex 1 X M 2 □ F 7. Age (In yrs. last birthday) **Funeral** Country Maryland Days Hours Month, Day, Year, 1940 216-38-1338 71 Yrs Director Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location death with the Maryland Director must be notified 1 Yes 2 No Cumberland Maryland Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö Funeral 23a 21502 **USA** 10301 Christie Road NE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. ıral", or iten I Examiner ı Black, White, etc. 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir Completed by ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Salesman Tire Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Hope Ellen Hoffman George Bernard Allen, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16438 Duck Hawk Drive NW, Frostburg, Maryland, 21532 John Allen, Sr. - Brother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Parruary 11, 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place)
Cumberland Crematory Cumberland, Maryland 2012 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licens Eichhorn-McKenzie Funeral Home P.A. 22. Name and Address of Facility Lonaconing, MD 21539 8 East Main Street 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a cor Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine Due to (or as a conse -transit Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 5 Other (specify) Pregnant at time of death been signed by the a should be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s has autopsy perform 24 hours after death.

Funeral Director: After this certificate 1 ☐ Yes 2 ☐ No Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 2 🗆 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Medical Certificate: 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred 5 Pending 1 Natural injury Accident Investigation filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

State Registrar

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сотрые within 2 To the F the

29a. Certifier

29b. Signature and title of certific

31. Date filed (Month, Day,

AJ1357/12

5

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

12

Nat 1 Hay

Extifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D0017565

L2 Vale, 100 21502

29c. License number

29d. Date signed (Month, Day, Year)

n. 11, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ 2012 0759 January Mark Allen Anderson Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Carroll 888 Deer Ridge Dr. Westminster Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth Social Security Number **Funeral** Months Hours 214-35-1956 1**½** M 2 □ F **Director** 20 Yrs. Jan 14, 1992 Maryland Usual Residence of Deceden 10d. Inside City Limits 28a-f show Oa. State 10b. County 10c. City. Town or Location aţ Director be notified 1 Yes 2 No MD Carroll Westminster 10g. Citizen of What Country? 10f. Zip Code ò 10e. Street and Number 23a Funeral USA 21158 "natural", or items 23 888 Deer Ridge Dr. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced White Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 2 should be filed within 72 lith and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4 or 5+) N/A N/Aother traumatic event, the Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Rachel Lynn Hurlburt Allen Scott Anderson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) of Health 888 Deer Ridge Dr. Westminster, MD M/M Allen Anderson Parents 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Page 1 þ Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State Crestlawn Mem Gardens 1/20/12 Marriottsville, MD 4 \square Donation 5 \square Other (Specify) 22. Name and Address of Facilit Pritts Funeral Home & Chapel, PA 21. Signature of Funeral Service Ligensee 412 Washington Rd. Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury -transit **Hospital or Attending Physician:** The law requires that the death certificate be executed 24 hours after death. and that initiated events Due to (or as a consequence of) resulting in death) Last physician ar Physician/Medical Division of Vital Records, P.O. Box 68760 as the attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Year 2 No signed by the at Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed After this certificate has been si funeral director, page 2 should I 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? Yes 2 No 1 ☐ Yes 2 ☐ No To the Funeral Director: After this certifics completely filled in by the funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical Be 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 1 Natural work 5 Pending 1 Yes 2 No Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 24 hours a Medical 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month,

State

6221

Registrar
DHMH 17 Rev 06-2011

who completed cause of death (Item 23a) Type, Print)

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2-00322		Please Type or Print in Black Indelible			jible.	
ric Christophe	r Alt	otato of maryland / Dopartmont		ygiene	2011	2 0160
		Registrar	of Death		g. No. 4 U 1	2 0100
Physic		Decedent's Name (First, Middle,Lest)		Date of Death Month	Day Year	3. Time of Death
Medical Exam	ıner	Eric Chriscopher Arcends		January 11	, 2012	1412 hrs
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
		223 Belle Hill Road	Elkton		Cecil	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday)	If Under 1 Year If Under 24Hrs Months Days Hours Min	-	h(MM/DD/YYYY) 9. Birt Foreig	n
Director		221-68-8013 1XM 2 F 27	rs. Days Hours I	06/11/	1984 Co	intry) Delawar
		Usual Residence of Decedent				
W 203		10a. State 10b. County 10c. City, Town or Loc	cation			10d. Inside City Limits
Maryland 28a-f show 1 at once.	5	DE New Castle Newark				1 Yes 2 X No
Maryl 28a- d at e	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Cour	itry?
eath with the Maryland items 23a or 28a-f sho ust be notified at once		768 Old Baltimore Pike	19702		USA	
n witi	Funeral		Vas Decedent of Hispanic Origin? (Sp f Yes, specify Cuban, Mexican, Puerto		14. Race - Ameri White, etc.	can Indian, Black,
deat or ite	<u>چ</u> ا	1 Yes 2X No	_	radan, did.)	711110, 510.	
after in	ğ	l or Dates:	Yes 2 X No specify:			hite
17215-0036 Id be filed within 72 hours afte Aental Hygene. arked other than "natural", event, the Medical Examines		15. Decedent's Education (Specify only highest grade completed) 16a. Decedenting	ent's Usual Occupation (Give kind of v most of working life. DO NOT use reti		16b. Kind of Business/I	ndustry
27 n 72	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	sociate		For Famil	y
withi iene, Med th	Ĕ	12			Business	i
Filed Hyg			18.Mother's Name	•		
21215-0036 and be filed within 7 Mental Hygiene. marked other than	o Be	Richard Altemus 19a. Informant's Name/Relationship (Type, Print) 19b. Mai		zley Be		7: 0-4-1
Shoul Shoul	ĭ		ing Address (Street end Number or f			
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiene. tent 71 is marked ofter than "natural", or items 23a or 23a-f also renamatic event, the Medical Examiner must be notified at once		` '	N. Bluff Rd. Ches	Date Date	City, MD 2 20c. Location - City or	1915 Town State
Ores 1 s of He t		1 Bunal 2 XX Cremation 3 X Removal from State crematory or	other place)			
Pag ment tant:		4 Donation 5 Other Specify: McCrery	& Harra Crematory	01/17/	2012 Wilmi	ngton, DE
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filled within 77 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other renamile year, the Medical		21. Signature of Funeral Service Licensee M 00 7 6 6 22	. Name and Address of Facility IcCrery & Harra Fu	meral Ho	omes & Crem	atory, Inc.
		23d. Part I. Enter the disease, or complications that caused the death. Do not enter				9803
Physician /Medical		failure. List only one cause on each line.	r the mode of dying, such as cardiac of	r respiratory arre	st, sлоск, ог пеагt	Approximate Interval Between Onset end
Examiner		Immediate Cause (Final disease a. Atherosclerotic car	<u>diovascular disea</u>	se		Death
		or condition resulting in death) Due to (or as a consequence of):				
	3E	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
	nin	cause. Enter Underlying Cause				
=	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
760, irate be executed by physician and the burial - transit	calE	d	1/ 0 7 10 -			
be exelician		X AMENDED 18, per fh, g92 23a.PII.27, per ME	2 4 2-7-12 sm g923 1/27/12 TRT			
760 cate l	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery	
lox 687 leath certific e attending p	ian	past 12 months?	Fetal death 3 Ectopic pregna	incy	Month D	ay Year
Sox 6 leath cer e attendii for use a	sic	1 Yes 2 No 9 Unknown 9 Unknown	Other (Specify)			
D. B. the de by the	Ph	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tob	pacco use contribute to t	he cause of death?
ires that the signed by the detached	by	Dilated cardiomegaly; complicatio	ns of obesity	1 Yes	2 No 3 Prob	ably 4 🗹 Unknown
ords, w requir us been s	Completed			24a. Was a		opsy findings available
COT law r has t	ď	myocardial bridging		autops perform	ned? death?	ompletion of cause of
tal Rection: The certificate	Co			1 ✓ Yes 2	No 1 ✓ Ye	s 2 No
ital Recicion: The	Be	25. Was case referred to medical examiner?	26.Place of Death (Check			
FVi Physi arthis	To	1 Yes 2 No			Residence 6 🗹 Other:	Scene
n of ding Ph. After ti		1 X Notural (Month, Day, Year)	of Injury 28c. Injury et Work?	28d. Describe no	ow injury occurred	
Sion Aften death ctor: y the	ati	2 Accident Investigation				
ivit lor/ after Dire	ţį	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, st	reet, factory, office building, etc.	28f. Location (St or Town, Sta	reet and Number or Rur ate)	al Route Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Faneral Director: After this certificate has been signed by the attending physici completely filled in by the faneral director, page 2 should be detached for use as the buri	Certification:	4 Homicide determined (Specify) 29a. Certifier 1 Certifier Physician To the best of my knowledge death according to the control of the contr				
n 24 be Fn	ca	(Check only Certifying Physician: To the best of my knowledge, death od				
To th withi To th	Medical	and manner stated.				
	2	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mon	
h		Tati Winca	O.C.M.E.		January 12, 2012	
Y		30. Name and address of person who completed cause of death (Item 23a)	000 M Paliman Charles	altimass 145	24222	
- 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1		Patricia Aronica-Pollak MD. Assistant Medical Examiner	500 vv. pailimore Street, E	allimore, MD	21223	
S Regis	tate trar		arked			

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ William Alt La Ronald Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Allegany WMHS-RMS Cumberland If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Jan 2, 1936 **Director** 220-32-2554 1 🛛 M 2 🗆 F 76 28a-f show permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified Oldtown MD Allegany 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21555 USA 14310 Old Oldtown Road SE items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, "natural", or iten edical Examiner I Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates. Specify. Completed 3 Widowed 4 Divorced Vietnam white er than "natur, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 9 <u>viation worker</u> Bell Helicopter Department of Health and Mental Hygic Important: If item 27 is marked other any injury or other traumatic event, the once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ida Nicum Marvin Alt 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, MD 21555 14310 Old Oldtown Rd. SE Oldtown Sunee Alt wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Xremation 3 Removal from State 1/18/2012 Scarpelli Funeral Home, P.A. MD Cresaptown 4 Donation 5 Other (Specify) 22. Name and Address of Facility Scarpelli Funeral Home, PA Funeral Service L gnature 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year the a signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? page 2 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certificate: To 1 Yes 1 Inpatient 2 FR/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of After t 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director; Al Accident Investigation Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier pletely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certified 29d. Date signed (Month, Day, Year)

5 8m

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month,

JAN 2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 20T2 Рм Jänuary 2056 Gene Raymond Aubry, Sr. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death E1kton Ceci1 Union Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs Months Days Hours Min. . Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 😿 M 2 □ F Months FEB^{nth}8^{Day,} 1954 Pennsylvania Director 179-46-4290 57 Usual Residence of Decedent : 23a or 28a-f show ust be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Ceci1 Earleville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 44 Maryland Avenue 21919 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14 Bace - American Indian. Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: White If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Electrician **Electrical** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leopold Paul Aubry Beatrice Naomi Bixler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie Aubry/Wife 44 Maryland Avenue, Earleville, MD 20b. Place of Disposition (Name of Penning Conville Presbyterian Cemetery 20a. Method of Disposition 20c. Location - City or Town, State January 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21, 2012 Atglen. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, MD 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Minutes Medical Due to (or as a consequence of Examiner PneuMoni Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Day Pregnant at time of death as been signed by the 2 should be detached 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? δ Coronari 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 2 No 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 I DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending To the Hospital or Attendia within 24 hours lifter death. To the Funeral Pirector: At completed filled in by the fu 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

30 ly

State

30 Name and address of persor

Date filed (Month)

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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Richard Andrew Albright, Sr. January 2012 1532 РМ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 9 Reed Hartnett Street Ceci1 E1kton Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Hours JAN 26, 1919 1 🛛 M 2 🗆 F Months Michigan Director 381-05-0798 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 X No Maryland Ceci1 E1kton 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 9 Reed Hartnett Street 21921 United States 12. Was Decedent Ever in U.S. 1940or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces?
1 X Yes 2 □ No Black White etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after 1962 1 ☐ Yes 2 🔀 No Specify: If Yes Give 'natural", Specify. 3 X Widowed 4 ☐ Divorced White Year or Dates event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) Chief Radioman United States Navy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Idora Rose Lee Noah Andrew Albright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau Craig D. Albright/Son 614 W. Chestnut Street, West Chester, PA 19380 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Gilpin Manor Memorial Park Memorial Park 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State January 4 ☐ Donation 5 ☐ Other (Specify) 2012 Elkton. MD Hicks Home for Funerals, of Funeral Service Licensee 22. Name and Address of Facility 103 W. Stockton Street, Elkton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician oca-de disease or condition resulting in death) Medical Due to (of as a consequence of) Examiner Sequentially list conditions, it any leading to invest the cause. Enter Underlying Cause (Disease or iinjury ner or as a consequence of Exami the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed heroscleros and that initiated events Due to (or as a consequence of resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 5 Other (specify) Day Year been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed this certificate 2 🗆 No 1 Yes Yes 2 No Be (25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Hospital: Other: ျှ 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director After completed filled in by the funeral 1 Natural 5 Pending work? Accident 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suiciae 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier M John A. Billon,

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State Registrar 31. Date filed (Month

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 9:30 A 2012 Physician/ January 6, Edward J. Ames, III Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Montgomery Ashton 17621 Tree Lawn Drive Birthplace (State or Foreign Country) If Under 8. Date of Birth (Month, Day, Year) Year 7. Age (In yrs. last birthday) If Under 1 6. Sex Social Security Number **Funeral** Hours Min 75 215-32-6398 **™** M 2 □ F **Director** April 18,1936 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f show 10b. County 10a. State 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at Director 1 Yes 2X No **Ashton** MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe United States Funeral 20861 17621 Tree Lawn Drive Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. med Forces?
X Yes 2 No 1 Never Married 2 Married 1 X Yes If Yes, Give þ 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 White 3 Widowed 4 Divorced Year or Dates. Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 1 and 2 should be filed within 72 f Health and Mental Hygiene. item 27 is marked other than ' College (1-4 or 5+) Newspaper/Research Fac Elementary/Secondary (0-12) Engineer/Manager 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) ည Jean E. <u>Pearson</u> Edward J. Ames, Jr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 17621 Tree Lawn Drive Ashton, Maryland 20861 Carol G. Ames/wife 20c. Location - City or Town, State or other 20b. Place of Disposition (Name of Date 20a. Method of Disposition Department of H Important: If ite any injury or oth once. 1 X Burial 2 Cremation 3 Removal from State Pikesville, MD 01/11/2012 Druid Ridge Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc 21. Sign of Funeral Service Lic 4112 Old Columbia Pike Ellicott City, MD 21043 nomac 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events and I-transit executed Due to (or as a consequence of): resulting in death) Last signed by the attending physician a ld be detached for use as the burial-Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) Month in the past 12 months? Pregnant at time of death Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 Unknown 1 Yes 2 No page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate has performed 1 Tyes 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical Be Other: Residence 6 Other (Specify) Hospital: 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 2 X No 1 🗌 Yes မ 28b. Time of 28c. Injury at 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 27. Manner of Death Natural Certificate: work? 5 Pending after death. Investigation Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be filled in by determined within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed Month, Day, Year, ess of person who completed cause of death (Item 23a) (Type, Print) LIZABETH 31. Date filed (Month egistrar's Signatur State

Registrar

reached

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year 0 5 - 10 \ 2 Physician/ Michelle R. Armaly Mont 19:18 M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Laurel Regional Hospital Laurel **Funeral** 6. Sex 7. Age (In yrs. Jast birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🔀 F Days Hours OCT 18, 1964 Mary Yand **Director** 28a-f show 10a, State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Prince George's Beltsville Maryland 1 🗌 Yes 2 💆 No 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral United States 10904 Dresden Drive 20705 permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces?

1 Yes 2 No Be Completed by 1 X Never Married 2 ☐ Married Black, White, etc. Specify: White Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give 3 - Widowed 4 - Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) none none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Michael Armaly Dolores Kellogg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy A. Tolbert - Residential Provider 5020 Sunnyside Avenue, #206 Beltsville, MD 20705 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State cemetery, crematory or other place) Metropolitan Crematory 1/13/2012 4 Donation 5 Other (Specify) Alexandria, Virginia 21. Signature of Funeral Service Licensee Bonard Tome, PA 02 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Sepsis Syndrome disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): burial-transit Cause (Disease or imjury that initiated events and Due to (or as a consequence of): resulting in death) Last ng physician a Physician/Medical Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for Day Year Pregnant at time of death signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, cate has been signated by page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performed? Yes 2 No 2 X No 1 Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 X No Hospital Other မ 1X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 X Natural e Hospital or Attending Po 124 hours after death.

Funeral Director: After the Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending 1 Yes 2 No Accident Investigation the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🖎 Certifying Pysician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying Norse) Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check r. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) January 9, 2012 D0063580 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) acoub Dusen 7300 Van 31. Date filed (Month, Day, State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ Jan. 2, 2012 6:00 A M Alice Rose Beins Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bethesda Health & Rehabilitation Bethesda Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth Funeral Days Hours April 13,1930 1 □ M 2 🛛 New York 087-22-7399 81 Director Usual Residence of Decedent 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10d. Inside City Limits ms 23a or 28a-f sho must be notified at Director Md. Montgomery Bethesda 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a . Examiner must be Funeral 5721 Grosvenor Lane 20814 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc 1 X Never Married 2 Married Yes 2X No þ Baltimore, Maryland 21215-0036 1 Yes 2x No Specify White Specify Completed 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Never Worked None Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hugh Michael Beins Elizabeth Rose McDermott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Kocornik/ Sister 29 Cleveland Rd., Caldwell, NJ 07006 or other 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State injury c 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crem Alexandria, Va. MO1315 22. Name and Address of Facility DeVol Funeral Home 2222 Wisconsin Ave., NW., Washington, DC 20007 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Acute Pulmonary Embolism Day disease or condition Medical resulting in death) Examiner Deep Vein Thrombosis 2 Months Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying n and Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death the a Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diabetic Mellitus, Hypothyroid, Seizure Disorder, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death? Schizophrenia, Dementia 24a. Was an this certificate has autopsy 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred injury XNatural 5 Pending 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 17656 Li Civern January 4, 2012

Registrar
DHMH 17 Rev 7/2009

State

Tipaporn Woodward, MD 7830 Old Georgetown Rd. #C15 Bethesda, MD 20814

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 201

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State	ate of Mary				d Mental Hy	giene	12	016	13
	-	Registrar 1. Decedent's Name (First, Middle, Last)		Cer	tificate of L)eath	2. Date of De	Reg. No. 4	1 4	0101	1 0
Physicia		Joan Margaret	Baker				January		Year 12	3. Time of Death 8:30	a M
Medi Exami		4a. Facility Name (if not institution, give street	and number)		4b. City, Town, or	Location of De		4c. County		0.30	
		11507 Highview Avenu	ıe		Silver S			Mon	tgome	ery	
Funeral Director		5. Social Security Number 6. Sex 049-34-6406		yrs. last birthday)	If Under 1 Year Months Days	If Under 24 H Hours Mi			9. Birthp	lace (State or Fore	eign
the state of the state of	١.	U49−34−64U6 ↑ ☐ M :	^{2 K F} 70	Yrs.			Jan. 20	, 1941		CT	
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Man, 28a-i otifie	Director	MD Montgomery	7	Silve	r Spring					1 Yes 2X	No
th the 3a or t be r	al	10e. Street and Number 11507 Highview Aver			10f. Zip Code			10g. Citizen of W		try?	
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003 urs af tural", al Exa			Yes, Give ear or Dates.	1	☐ Yes 2 🔀 No	Specify:		Specify	hite		
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Val	2	James Louis Leptic				Ruth	Marie Ber	nnett			
ire, Maryland 21215-0036 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	4	19a. Informant's Name/Relationship (Type, Pri	,				Rural Route Number			*	
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Division of Vital Records, F.O. Box 08/00 within 24 hours after death certificate be executed within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial personal process.	edical	d									
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		29b. Signature and title of certifier		,	29c. License			e cause(s) and ma			
12		furter h	Down !	MA	D227	75		Jan. 4,	2012	2	
		30. Name and address of person who complete Frederick Barr, MD	ed cause of death (I	tem 23a) (Type, Pr	int)	#1300	Chevy Cha	NG M	20015		
Stat						# 1300,	onevy ona	ise, MD	20815)	
Registra	ır	31. Date filed (Month, Day, Year) 2012	Deman !	A. Acu	()						

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			_	For State Registrar		State of M	larylan			te of L			lental Hy	/gien Reg. N	20	12	016	5 4
	F	Physicia Medic	al .	1. Decedent's Nam	N D.	BUNTING	SR.			_			2. Date of De JAN .		Day 20	Year 12	3. Time of D 2039	eath M
		Examin	er			ive street and number) AL HOSPITA	L			y, Town, or RLIN	Location	of Death			c. County of WORCE			
Ī		Funeral Director		5. Social Security N	842	Sex 1 X M 2 □ F	ast birthday) Yrs.		If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. APRIL 22,						9. Birthplace (State or Foreign DELLAWARE			
	rland	f show od at		Usual Residence of 10a. State	10b. County	<u></u>	10c. Cit	y, Town or Lo	cation							1	0d. Inside City	
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,	Maryiand 2 should be filed	Mental F arked o atic eve	의	17. Father's Name (First, Middle, Last) ALFRED COOK BUNTING SR. 18. Mother's Name (First, Middle, Maiden Surname) MAGGIE DAVIS														
	d 2 shoul	alth and I		19a. Informant's Na BRUCE A.	,			I .					l Route Numb ISBURY				code)	
01/04	baltimore, permit. Page 1 and	nt: If iten				Removal from State		Place of Disponentery, createry, Clance Clan	matory or	r other plac	e)	1/10	Date /12		Location - (
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7	BOX 66 / 60 e death certificate be	within 24 nours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		IF FEMALE: 23b. Was decedent pregnant In the past 12 months? 1											23d. Date of delivery Month Day Year			ar
200	requires that the	signed by d be detac	d by Ph	Part II. Other signif	ficant conditions	contributing to death	but not res	liting in the i	underlyin	g cause giv	ven in Par	t I.					e cause of dea	
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DHMH 17 Rev 7/2009

P.O. Box 68760

Records,

Division of Vital

Registrar

DHMH 17 Rev 7/2009

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Livings In Road Fort WASHINGTON

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registr

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 1 - For State Registrar Certificate of Death 1 Decedent's Name (First Middle | ast) 2. Date of Death 3. Time of Death Physician/ Month Eva Mencer Barker January 9:34 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne **Arundel** Year If Under 24 Hrs.
Davs Hours Min. If Under 1 Social Security Number . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days (Month, Day, 1 □ M 2 🕱 F Months Country) Year) Director 235-32-0143 87 Virginia March West Usual Residence of Decedent 28a-f shov 10a. State er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3909 New Haven Court, Apt. A5 20716 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Force Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: 3 X Widowed 4 Divorced Specify. Completed White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) within 72 Elementary/Seconday (0-12) College (1-4 or 5+) 11 Claims Examiner Hartford Insurance Co. Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) (unavailable)|Estella Mencer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Gregory W. Barker / 6608 Alexis Drive, Bowie, MD Baltimore, 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ■ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland National Mem. Pk 1/11/2012 Laurel, Maryland 21. Signature of Funeral Service Licensee 4739 Baltimore Avenue 22. Name and Address of Facility Claudet Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequ Examiner Sequentially list conditions, Examine cause. Enter Underlying requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of resulting in death) Last Physician/Medical Box 68760 the attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Pregnant at time of death signed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 🗌 Yes 2 00 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an Hospital or Attending Physician: The law autopsy performed prior to completion of cause of death? page 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: PInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 🗌 Yes 2 No ဂ္ 4 Nursing Home 5 Residence 6 Other (Specify, After this Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural injury 5 Pending M 1 Yes 2 No death Accident Investigation the 24 hours after deat Funeral Director: Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: In the basis of xamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the F Certifying Nurse P actioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and ti 29d. Date signed (Month, Day, Year)

State
Registrar

JAN 0 9 2012

30. Name and a

32. Registrar's Signature

as of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Leonard Raymond Januarv 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Wicomico Nursing Home Salisbury Wicomico Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Days Hours Min Director 211-22-9450 91 07/12/1920 Pennsylvania Usual Residence of Decedent 28a-f show aţ 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director permit. Page 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyglena. Important if frem 27 is marked other than "natural", or items 23a or 28a-f st mportant; if item 27 is marked other than "natural", or other traumatic event, the Medical Examiner must be notified any injury or other traumatic event, the Medical Examiner must be notified. 1 Yes 2 X No Maryland Wicomico Salisbury 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 31328 Johnson Road 21804 USA . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian, Armed Forces?

X Yes 2 \(\sum \) No Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 K No Specify: If Yes, Give Year or Dates. Army Specify 3 X Widowed 4 ☐ Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 11 Shoe Store Owner/operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William John Buck Mable Kate Raudenbush 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda C. Morris/Friend 1102 Nevins Place, Salisbury, MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place Springhill Memory Gardens 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/5/2012 Hebron, MD 21. Signature of Funeral Service Li Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Part 1. Enter the disease, or complication and caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. E to Judan, ing Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy o in the past 12 months? Day 5 Other (specify) Pregnant at time of death 9 | Unknown 9 Unknown Division of Vital Records, P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an Were autopsy findings available certificate has autopsy prior to completion of cause of death? ☐ Yes Yes 25. Was case referred to dical examiner? Be 26. Place of Death Check only one) Hospital ည 1 Tyes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) After this f Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending injury thin 24 hours after death.

the Funeral Director: After mpletely filled in by the fun 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical 🗜 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signatu 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 910 Easternshore Dr Salisbury MD 21804 Thimmarayappa, MD Mahesha egistrar's Signatur

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Franklin R. Bailey 2012 January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince George Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Hours **Director** 232-50-4669 1 ▼ M 2 □ F 78 Feb. 7, 1933 West Virginia Usual Residence of Deced 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director notified 28a-f Charles 1 Tes 2 No Maryland Waldorf ms 23a or 2 must be no 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 2424 Peartree Ct. 20602 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 0 ģ 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: "natural". Completed 3 Widowed 4 Divorced White Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) an Elementary/Secondary (0-12) College (1-4 or 5+) 12 Operator Waste Water Management other 1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H 27 is marked of traumatic even မ Harry A. Bailey Bertha Elizabeth Pritchard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health attem 27 Brenda L. Lohman Daughter 2424 Peartree Ct., Waldorf, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Jan. 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 9 9 2012 Department of Important: If any injury or ☐ Donation 5 ☐ Other (Specify) Waldorf, Maryland Trinity Memorial Gardens Williams Funeral Home, P.A. 4270 Hawthorne Rd., Indian Head, Md. 20640 21. Signature of Funeral M00668 23a. Part 1. Enter the se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart faily e. List only one cause on each line Immediate Cause Eine CARDIOCARDO Ph_sician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to for as a consequence of Cause (Disease or injury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be after death. P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death signed by the at d be detached for Unknown 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 X Yes 2 □ No 3 □ Probably 4 □ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an this certificate has perform 2 🗌 No Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No မ 1 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: after death. Director: After 1 🖪 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide M Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Hospital within 24 hours a To the Funeral I Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jan 1 Physician/ 201 2:50 A Ruth M. Brown Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince George's Hospital Cheverly Prince George's If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Aug 26, 1918 Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday, Funeral Director 578 26 4227 Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 X No Prince George's Maryland Upper marlboro 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 14628 Dunbarton Drive 20772 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married Yes 2 X No Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: If Yes, Give Year or Dates. Specify: Black. 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor General Accounting Office Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည William Slaughter Margaret Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gregory M. Brown (Son) Upper Marlboro, MD 20772 14628 Dunbarton Drive, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🗓 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Clinton, MD ee Crematory 2012 Jan 2. Signature of Furgral Service Ligensee 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road. Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line nset and Deatl Immediate Cause (Final ours Physician/ disease or condition resulting in death) Medical Due to (or as a nsequence of Examiner Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury use as the burial-trans and that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physician should be detached for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death ☐ Pregnant a Yes g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page 2 performed? Yes 2 No this certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ည 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: After work? 1 Yes 2 No Natural Natural 5 Pending Accident Investigation 24 hours after death completed filled in by the Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1951 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

within 2

Registrar

only one

29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of person who completed cause

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DHMH 17 Rev 7/2009

of death (Item 23a) (Type, Print)

32. Re

29d. Date signed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For AMEND#8 per FH State of Maryla State 1/10/2012 ANNE ARUNDEL CO. CMH Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 03 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min (Month, Day, Year, 51 219-64-2312 Director 1 M 2 F Maryland 15, 1960 Yrs Feb. Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits within 72 hours after death with the Maryland 10a. State 10b. County 10c. City. Town or Location Director Oueen Anne's MD Grasonville 1 Yes 2X No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeraf 21638 USA 5 Prospect Bay Drive West 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 X Married Completed by Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working Commercial/ life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Development 12 Office Manager d 2 should be filed wi alth and Mental Hygie 27 is marked other r traumatic event, tt Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Earle W. Young Joan Regina Flaherty Page 1 and 2 should be ent of Health and Men ar: If item 27 is marke y or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Earle Young / Father 5 Prospect Bay Drive West Grasonville, MD 21638 Baltimore, Date 04, 20a. Method of Disposition 20b, Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place, Jan. Department Important: If any injury or Baltimore, MD Metro Crematory, INC. 4 ☐ Donation 5 ☐ Other (Specify) 2012 21. Signature of Funeral Service Licenses CREMATION DIRECT 495 Ritchie Hwy, Severna Park MD 21146 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximation Interval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year 5 Other (specify) the 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by -OPHRENIA 1 Yes 2 □ No 3 □ Probably 4 □ Unknown should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has page 2 autopsy performed' after death.

Director: After this certificate 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1. Inpatient 2 ER/Outpatient 3 DOA the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 Natural 5 Pending work 1 Yes 2 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Hospital within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. no completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State

Registrar

Date filed (Month, Day,

Year

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32. Registrar's Signature

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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be nonce.		21. Signature of Fur	neral Service L	icensee	(T) OA		22. Name and Add	ess of Facilit	^{ty} Bea.	ll Fune:	ral 1	Home		
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To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	edical	(Check 2	Medical E	Physician: To the backaminer: On the ba	sis of examination	on and/or inve	stigation, in my opi	nion, death o	ccurred at	the time, date ar	nd place,	, and due to	the cause(s	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ROON BRANHAM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel **Funeral** Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year)
Oct 29 1 Months Days Hours Min 424-48-8113 Director 1 M 2 □ F 74 Yrs. 1938 Kentucky Usual Residence of Decedent show 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural". or Items 99a αν 9αα Δουστουν 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Annapolis 1 Tes 2 X No 10f. Zip Code 10g. Citizen of What Country? by Funeral 19 Silverwood Circle Unit 9 21403 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Xes 2 No
If Yes, Give
Year or Dates:956-62 Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: 3 Widowed 4 Divorced Completed **Black** 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4 or 5+) 6vrs Assistant Area Director Juvenile Services Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) 2 Gordon W. Branham Sr. Annie Mae Shuford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Silverwood Circle Unit 9 Annapolis, Md. Judith V. Branham(Wife) other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or or 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 1 - 4 - 12Baltimore, Md. 21. Signature of Funeral Service Licensee W Manne a Recense of Facility Sons Mortuary, P.A. 1922 Forest Dr. Annapolis, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final WEXAST Physician/ ROSTATE disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of): Cause (Disease or injury that initiated events burial-trar resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Ö in the past 12 months? Day Pregnant at time of death Month Year 2 No g Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s Jas autopsy death? performed' certificate 1 Yes 2 No 1 Yes 2 No after death.

Director: After this certific d in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2. No ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1-Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after de To the Funeral Directo completely filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifiei 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie Name and address of person who completed cause of death (Item 23a) (Type, Print) DEFENSE HWY ANN APOUS MOZIGOI

Registrar

JAN 05 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2012 Year Physician/ Month РМ January 2:33 Eldridge M. Bowen Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Frederick Calvert Calvert Memorial Hospital g, Birthplace (State or Foreign 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. **Funeral** 12-23-1919 Mary Land **Director** 92 218-16-3221 Usual Residence of Decedent or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 72 hours after death with the Maryland Examiner must be notified at Director 1 🗌 Yes 2 💢 No Prince Frederick MD Calvert 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Numbe Funeral **USA** 20678 420 W. Dares Beach Road, Apt. 410 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exar Specify: 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Anne Arundel County Elementary/Seconday (0-12) College (1-4 or 5+) Public Works Dept. unknown <u>Truck Driver</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mollv Montgomery С. Bowen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20678 420 W. Dares Beach Rd., Apt. 410, Pr. Frederick, MD Patricia Bowen, Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 01-11-2012 Friendship, MD 4 ☐ Donation 5 ☐ Other (Specify) Friendship Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD MO0715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final FAILURE CONGESTIVE Pnysician/ disease or condition Medical resulting in death) Examiner TONTH Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that the death certificate be executed physician and s the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 attending p IF FEMALE: If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Yes 2 No the detached g Unknown P.O. I þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown of Vital Records, Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed. Yes 2 No. has death? within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 X ER/Outpatient 3 I DOA မ 28b. Time of 27. Manner of Death 28a. Date of injury 28d. Describe how injury occurred 28c. Injury at work? Certificate: 1 Natural (Month, Day, Year) 5 Pending Division 1 ☐ Yes 2 ☐ No Investigation 2 Accident 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital Medical Excertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of pers on who completed cause of death (Item 23a) (Type, Print)

State Registrar

CHR15700 31. Date filed (Month, Day, Year) MORROL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month. 8:25 UNG anua Medical 4a. Facility Name (if not institution, give street and number)

Mentos

Mentos City, Town, or Location of Death Examiner 4c. County of Death Medi WASHINGLON MARILLE If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Min (Month, Day, Year) 233-48-6394 **Director** 1 🗆 M 2 🗓 F 79 March 14 1932 West Virginia Usual Residence of Decede 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits with the Maryland Director notified 28a-f 1 ☐ Yes 2X No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 6 10g. Citizen of What Country? ms 23a or must be Funeral 21740 USA 236 Winding Oak Drive permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12 Was Decedent Ever in U.S. Black White etc. þ 1 Never Married 2 X Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 0 Sales Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Melvin G. Sanders F. Ruth Jack 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> William Burgan - Husband</u> 236 Winding Oak Drive, Hagerstown, Md. 21740 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 1/11/12 Williamsport, Maryland Greenlawn Mem. Park Signature of Funeral Service Li 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph_sician/ disease or condition resulting in death) Medical is ouence of): Due to Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tra Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 5 Other (specify) Month Dav Year Pregnant at time of death tor: After this certificate has been signed by the a the funeral director, page 2 should be detached Yes No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the causa of death? þ 1 Yes 2 No 3 Probably Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy ZNo 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one. examiner? Hospital Other: ၉ 1 🗌 Yes ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 28a. Date of injury (Month, Day, Year) anner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 2 No Accident Investigation 24 hours after death Funeral Director: / Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical_traffiler: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifing Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 the only one 29b. Signature 29c. License number 29d. Date signed (Month. Day, Year) 2

State Registrar

JW-L

s of person who comple

TON

31. Date filed (Monti

se of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Boyd, Sr. Month James Bruce 1320 PM 2012 Medical January 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death 4b. City, Town, or Location of Death Allegany Western MD Regional Medical Center Cumberland Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Days Hours Min 1 🛛 M 2 🗆 F 76 215-34-2648 **Director** 07/11/1935 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at any pines. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director WV Carpendale Mineral 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 26753 Funeral 2 Skyline Drive USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, vvas Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No 1955— If Yes, Give Year or Dates. 1959 Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: 3 Widowed 4 X Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Tire and Rubber Sheet Metal Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Bruce Boyd မ Cecil Jane Hager 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 912 Maryland Avenue, Cumberland, MD James B. Boyd, Jr. / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Cem @ Rocky Gab 01/17/2012 Flintstone, MD of Funeral Service Lio 22. Name and Address of Facility Adams Family Funeral Home, 404 Decatur Street, Cumberland, MD 21502 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Metastatic Colorectal Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physician and eted filled in by the funeral director, page 2 should be detached for use as the burial-transit Exam Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy Live Birth 2 Fetal dea Pregnant at time of death in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Liver Failure 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No Yes 2 X No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 2 💢 No 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 🔲 Yes 2 🔲 No 1 X Natural 5 Pending Accident Investigation completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one 29b. Signature and title of certifier 29c. License number 2 29d. Date signed (Month, Day, Year,

Registrar
DHMH 17 Rev 7/2009

State

and

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Bhandari, M.D.,

D0071867

12500 Willowbrook Road, Cumberland, MD

January 12, 2012

21502

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· D			23a. Part 1. Enter shock, or hea Immediate Cause	art failure. List onl	omplications that cau y one cause on each	line.	n. Do not ente	er the mode	N	g, such as cardiac	or respiratory ar	rest,		Approxin Interval E Onset ar	Between		
	h _{sician/} Medical		disease or condition resulting in death)		a. Due to (or	as a cons	uence of):	4	W/3	case				107			
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Division of Vital Records,	ifter dex Director	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could no determin	28e. Place of	Injury - At ho		reet, factory,	office		28f. Location (City or Tox		Number o	r Rural Route Nu	ımber,		
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the H	To the hospital or Attentioning Frightson. The law requires that the death continuous be within 24 bloors after death. To the Pubreal Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the but	Med	(Check only one) 29b. Signature and	3 🔼 centifying N	aminer: On the basis	or examination the best of i	n and/or inves my knowledge	e, death occu	irred at t	on, death occurred the time, date and performed in the control of	place, and due to	the cause	s) and man	ner as stated. Month, Day, Year)			
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	4		30. Name and add	ress of person wi	no completed cause of	of death (Iten	1 23a) (Type, I	Drint\				- 1	.0.01				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene _ State Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 01^{Month} Anna K. Beachy 2012 5:50 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death WMHS Frostburg Nursing&Rehab Center Allegany Frostburg 5. Social Security Number 9. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days 1 🗆 M 2 💢 F Hours March 02, 1919 92 267-32-6883 Director Usual Residence of Decedent 3a or 28a-f show t be notified at and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hyglene. Health and Mental Hyglene. 42 is marked of other than "natural", or items 23a or 28a-f show ther traunatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Allegany Frostburg 1 X Yes 2 No 10e. Street and Number 48 Tarn Terrace 10f. Zip Code 10g. Citizen of What Country? Funeral 21532-U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Bace - American Indian. Armed Forces? 1 Yes 2 ☐ No If Yes, Give Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 No Specify. Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Daniel H. King Mary Mae Hollida 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Gary Beachy 31 Hawthorne Drive Maryland 21532-Frostburg 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1

■ Burial 2

□ Cremation 3

□ Removal from State cemetery, crematory or other place. Springs Cemetery Springs Pennsylvania January 17, 2012 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility loten Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition CORONAR Onset and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): physician and the burial-transit that the death certificate be executed Due to (or as a consequence of) attending physician Physician/Medical use as 1 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Petal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Por in the past 12 months? Month Year Day 1 Yes 2 No detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by To the Hospital or Attending Physician: The law requires I within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy performed' death? 1 ☐ Yes 2 ☐ No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Sursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide work? 5 \square Pending 2 🗌 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in the pasis of examination and or investigation and 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 02690 Herston 62012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nas

State Registrar Harjit Sidhu,

31. Date filed (Month, Day, Year)

JAN 17 20

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

/32. Registrar's Signature

925 Bishop Walsh Rd, Cumberland, MD 21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1 Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 P^{M} January 2:44 V. Bovkin Alice Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Kline Hospice House Mt. Airy Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min **Director** 578-36-3942 93 1 □ M 2 🕱 F Aug 8, 1918 Virginia 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director notified Maryland Frederick Frederick 1 X Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? ö must be r Funeral 21702 1421 Taney Avenue USA items 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates. "natural", or item ledical Examiner n Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 XWidowed 4 ☐ Divorced Specify. white Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Bakery Manager Food Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ James E. Yost Sally Catson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sue Corle - Daughter 5503 Doubs Road, Adamstown, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Memorial 1-7-2012 Frederick, Maryland 22. Name and Address of Facility Stauffer Funeral Home Sign ture of Funeral Service Hensee herrow Camille 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Dreumen Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) sician and burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician I for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Diobetes 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an pertengion page 2 autopsy performed 1 ☐ Yes 2 🗷 No Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospite ٥ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Medical Certificate: 27. Manner of Death 28c. Injury at 28b. Time of HUUSE 1 XNatural 5 \square Pending work 1 Yes 2 No ☐ Accident☐ Suicide filled in by the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year,

State Registrar

Ъ

Thomas

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

D5164

20/2

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2. Date of Death Day 2012 Physician/ January 4, 8:40 P BENSON JAMES Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Crumland Farms Health Center Frederick 8. Date of Birth (Month, Day, Yea Aug 12, 1 If Under 1 Year If Under 24 Hrs. Social Security Number 6 Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 214-16-9760 89 Maryland Director 1 🖺 M 2 □ F 1922 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified Maryland 1 Yes 2 No Montgomery Damascus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20872 USA 10541 Bethesda Church Road items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 0 þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify white "natural" Completed 3 Widowed 4 Divorced Specify. Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 17 is marked other than traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Brick laver Masonry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental 2 James Wade Benson, Sr. Temperance Mc Crossin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a 20872 10541 Bethesda Church Road, Damascus, Maryland Sharon Benson - wife item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once, Page 1 1 Burial 2 X Cremation 3 Removal from State Stauffer Crematory 1-8-2012 Frederick, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland Ollua samille 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or uspiratory arrest Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a c ///9 ouence of **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to for as a consequence of Cause (Disease or injury burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): physician Be Completed by Physician/Medical P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy Jas Yes Hospital or Attending Physician: Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 Yes 2 No မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 27. Manner eath 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 - Natural 5 Pending after death. 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation M the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f, Location (Street and Number or Rural Route Number, completely filled in by determined building, etc. (Specify) 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one) 29b. Signature and title 29c. License number Name and address of persor

Registrar

DHMH 17 Rev 06-2011

State

Date filed (Month, Day,

Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. for State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 2012 Year Physician/ Month 6:45 January John Batter, Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 01ney Montgomery Montgomery General Hospital 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Months Days Min (Month, Day, Year) Hours 579**-**16-9199 90 Director 1 🗷 M 2 🗆 F NY Feb. 14, 1921 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Yes 2 No MD Montgomery Rockville 10e. Street and Numbe r items 23a or ner must be n 10f. Zip Code 10g. Citizen of What Country? Funeral 16312 Hillcroft Drive 20853 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. 11. Marital Status the Medical Examiner rmed Forces?

X Yes 2 \(\sum \) No ö 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 within 72 hours after Specify:White If Yes, Give Year or Dates. WWII 1 ☐ Yes 2 X No Specify: 'natural", Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 5Ť Attorney Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Carl John Batter, Sr. Gertrude Irene Beyer traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health as Important: If item 27 is any injury or other trau 16312 Hillcroft Drive, Rockville, MD 20853 Gilberte M. Batter/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA Metropolitan Crematory 2012 there of Funeral Service Licensee Trancal Address of Foullins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. 23a. Part Approximate Interval Between shock, Immediate Cause (Final Onset and Death Ph sician/ disease or condition Medical resulting in death) sequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the buris Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year signed by the a Unknown P.O. Other significant conditions, contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Cancer 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has performed? certificate 1 ☐ Yes 2 ☐ No Yes 2 No To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 2 🐧 No 1 🗌 Yes ည 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 27. Manner of Death 28c. Injury at work? 1 🔲 Yes 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: X Natural 5 Pending 2 🗀 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 dertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title certifier 29d. Date signed (Month, Day, Year) 2 10+1

DHMH 17 Rev 06-2011

State

Registrar

18101 Prince Philip Drive, Olney, MD 20832

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Aruna Paspula, MD

JAN 1 0 2012

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Amend#8. PerinfrmntPGC1-20-12cr Certificate of Death
Registratement# s10e. 19a. &b. PerFHFCC1-17-12cr Certificate Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JAN. 6, 2012 2:25 PMM MAE S. BARNES Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE SEASON HOSPICE IPU RANDALLSTOWN 8. Date of Birth 4_20_1926 9. Birthplace (State or Foreign (Mpnth, Day, Year) If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min **Director** 85 1 🗆 M 2 🙀 F 157-18-1946 PHILA., PA Usual Residence of Decede 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location items 23a or 28a-f sho ner must be notified at Director 1 🟋 Yes 2 🗌 No HOWARD COLUMBIA MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? LANE Funeral 6262 DEEP EARTH LAND U.S.A. 21045 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 12 Was Decedent Ever in U.S. 11. Marital Status the Medical Examiner If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify: Armed Forces? ō 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates Specify: BLACK "natural", 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry I Hygiene. ADMISTRATIVE ASSISTANT life. DO NOT use retired) Elementary/Secondary (0-12) SOME COLLEGE ADMINISTRATIVE ASSISTANT AGENCY FOR INTERN.DEV. should be filed with and Mental Hygien I is marked other the Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ RUDOLPH SCOTT MAUDE **BROWN** other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code)
6262 DEEP EARTH LAND COLUMBIA, MD 21045 Department of Health a Important: If item 27 is any injury or other trains BRENDA J. COLWELL - DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State WASH. NAT. CEM. 1-14-2012 SUITLAND, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility PINCKNEY-SPANGLER F. H. Funeral Service Licenses 524 - 8TH ST., N. E. WASH., DC 20002-5236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Weinson disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or injury that initiated events and burial-tran Due to (or as a consequence of): resulting in death) Last physiciar Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as ding IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months? Por Month Day 5 Other (specify) Pregnant at time of death 1 Yes 2 Unknown the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 known Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? has or Attending Physician: 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? 6 Dother (Specify) Assisted Linn Other: 4 Nursing Home 5 Residence 1 Tes ည 1 Inpatient 2 ER/Outpatient 3 IDOA Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work?
1 Yes 2 No hours after death 2 Accident 3 Suicide Investigation filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or inventioning in the cause of th Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year, DA7683 Muller MD 12 Tayon rd 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Millo 2835 Smith Averm Smte 203 mo 21209 Balhvore 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

JAN12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ \mathbf{P}^{M} 2012 Sharon Victoria Barkley anuary Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Hyattsville Prince George Prince Georges Hospital Funeral Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign Months 1 □ M 2 🔽 F (Month, Day Country Director 577-02-9715 10/18/1965 Washington. DC Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Direct 1 Yes 2 No Maryland Prince George Riverdale 5 10f. Zip Code 10g. Citizen of What Country? 5600 54th Avenue #603 20737 U.S.A. Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No 11. Marital Status 14. Race - American Indian, Black. White, etc. þ 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Widowed 4 Divorced Completed Black Year or Dates marked other then "natumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Custodial Georgetown University Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Harold Barkley Jr. Gloria Ford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5600 54th Ave. #603 Riverdale, MD 20737 Ebonie Barkley/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of I
Important: If it
any injury or or Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Fort Lincoln Cemetery 01/17/2012 Brentwood, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Rd. Brentwood, MD 20722 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (6) ed by the attending physician and detached for use as the bunal-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy 5 Other (specify) Month Day Year 9 Unknown After this certificate has been signed by funeral director, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 3 Probably 4 Unknown 2 X No 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performa 1 Yes 2 No To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify 2 1 Yes Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After (Month, Day, Year) Natural 5 \square Pending 1 Yes Investigation Accident completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Fractioner: To the basis of my however, death occurred at the time, date and place, and due to the cause(s) and yill mer as stated. 29a. Certifier 29b. Signature and title of certifi 29c. License number Day, Year) (Month, Day, Year, State

Registrar DHMH 17 Rev 7/2009

Box 68760

Division of Vital Records, P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State		State o	f Marylar		artment of F		and Ment	tal Hygi	ene	112	01634
		Registrar 1. Decedent's Name (First	Middle Lac	<i>t</i>)		Cer	tificate of L	eath			g. No. C) (_	01034
Physic		Virginia		Irene		Danas			M	ate of Death Ionth	Day	Year	3. Time of Death
Med Exami		4a. Facility Name (if not in.			ther)	Brov		. L Al		nuary		012	10:25a ^M
LAGIII	nei	826 Marylan		Street and nam	iber)		4b. City, Town, or Hagers		of Death		4c. County	of Death ingto	n
Funera	Г	5. Social Security Number		ex	7. Age (In yrs.	last birthday)	If Under 1 Year		24 Hrs. 8 Da	ate of Birth	Wasii	lace (State or Foreign	
Director	_	215-84-7687	1	□м 2 🕅 F	X F 44 Yrs. Months Da			Hours		onth, Day, 1	^(ear) 1967	Count	yland
d d	٦.	Usual Residence of Deced	lent County								2707	1101	7 1 1 1 1
arylan a-f sh iled a	Director		,			ty, Town or Lo						1	Od. Inside City Limits
or 28%	E E	MD W 10e. Street and Number	ashing	ton	Ha	gerstov							1 X Yes 2 □ No
vith th	ā	826 Maryla	۸ اسم				10f. Zip Code			10	g. Citizen of \		try?
ems r mu	Funeral	11. Marital Status	nd Ave		dent Ever in U.	S 13 V	21740 Vas Decedent of His		ain? (Specify Ve	o or No		S.A.	
6 ter de mine	by	1 X Never Married 2	☐ Married	Armed For 1 Yes	ces?	Į.	Yes, specify Cuba	n, Mexican	, Puerto Rican,	etc.)		e - America ck, White, e	
JOG JIE af Urral"	ed	3 ☐ Widowed 4 ☐ D	ivorced	If Yes, Give Year or Da		1	☐ Yes 2 🕅 No	Specify:			Specify.	Whit	e
15-17 ho	ple	15. [(Specify on	Decedent's Ed ly highest gra	lucation de completed)			ent's Usual Occupa		t of working	1	6b. Kind of B	usiness Ind	ustry
thin than the M	Completed	Elementary/Seconday	(0-12)	College (1-	4 or 5+)	life. DO	NOT use retired)		•	- 1			
Hygi Other	Be (17. Father's Name (First, N	liddle, Last)			Casii	ler/Custo				Home I		rement
Maryland 21215-0036 12 should be filed within 72 hours after tith and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Exami	은	John W. Br							er's Name (First, ada M. S		uden Sumame	9)	
ary hould and N s ma		19a. Informant's Name/Re	lationship (Ty)	pe, Print)		19b Mailin	g Address (Street a	_	_		ity or Town S	State Zin C	ndo)
nd 2 sealth an 27 i		Linda M. Ha	rne/Mo	ther			Mulberr					21740	
of He		20a. Method of Disposition 1 Durial 2 K Cre	1		20b. F	Place of Dispos	sition (Name of eatory or other place		Date		0c. Location -		
Lim Page ment tant:		4 Donation 5 0	nation 3 L. Other (Specify	Hemoval from	State Sm 3		g Cremato		1/13/201	12	Smiths	burg,	MD
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at onnes.		21. Signature of Funeral S	ervice License	æ		22.	Name and Address	s of Facility	Rest	Haven	Funer	al Ch	ape1
		Januar	سان	1/2] 1	601 Penns	sylva	nia Ave	., На	gersto	wn, M	D 21742
		23a. Part 1. Enter the dise	ase, or comp e. List only on	ations that ca cause on eac	aused the deat th line.	h. Do not ente	r the mode of dying	, such as c	cardiac or respi	ratory arrest	3		Approximate Interval Between
Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	_	a	Cance	echi	Corce						Onset and Death
Examiner		,		Due to (d	or as a consequ	ience of):							
	ner	Sequentially list condition if any, leading to immediate	s, e	b. Due to (c	or as a consequ	ience of):							
uted Id ansit	Examiner	cause. Enter Underlying Cause (Disease or initiary that initiated events	5	2								- 24	
760 icate be executed physician and s the burial-transit		resulting in death) Last		Due to (c	r as a consequ	ence of):							
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687 ertifica ding p	Me ∣	IF FEMALE:		0 - 16 1								10000	
Box 68 death certific he attending ed for use as	cian	23b. Was decedent pregna in the past 12 months	110	3c. If yes, outc	irth 2 🗌 Feta	I death 3 🗌	Ectopic pregnancy	1				te of deliver	*
he de y the ched	Physician/M	1		9 Unkno	ant at time of cown	eath 5 🗆	Other (specify)				Mo	חנח נ	Day Year
Records, P.O. Box 687 The law requires that the death certific ate has been signed by the attending I page 2 should be detached for use as	by PI	Part II. Other significant c	onditions cor	ntributing to de	ath but not res	ulting in the un	derlying cause give	en in Part I.	. 23	Be. Did toba	cco use contr	ibute to the	cause of death?
ds,	ed t								().	1 🗆 Yes	2 🗖 No	3 🗌 Proba	ably 4 🗆 Unknown
Records, The law requires ate has been sig	Completed								24	la. Was an	24b. V	Vere autops	sy findings available
/ital Reco sician; The law i certificate has to irector, page 2 s	ĕ			-					_	autopsy performe	ed?	leath?	pletion of cause of
Vital lysician: is certifical director, p	Be	25. Was case referred to me examiner?	edical				26. Plac	ce of Death	n (Check only o	Yes 2 ine)	No 1	Yes 2	! LI No
hysic his ce	욛	1 ☐ Yes 2 ☑ No	H	ospital:	npatient 2 🗌	ER/Outpatient	3 DOA Other	. 4 🗆 Nur	rsing Home 5	Residence	ce 6 🗆 Othe	r (Specify)	-
ing P	Certificate:	27. Manner of Death 1 Natural 5	Pendina	28a. Date of (Month)	f injury , <i>Day</i> , <i>Year</i>)	28b. Time of injury	28c. Injury work?	at		_	injury occurre		
SIOF ttend death death stor: /	tij	2 Accident	nvestigation Could not be				M 1 □ Y	′es 2 □ 1	No				
Division of Vital To the Hospital or Attending Physician; While 24 hours after death. To the Funeral Director, After this certific completed filled in by the funeral director,	Sel	4 Homicide	determined	building	it Injury - At hoi g, etc. (Specify)	me, farm, stree	et, factory, office			cation (Stree y or Town, S		er or Rural F	Route Number,
Spita bours hours neral	ical	29a. Certifier 1 Cer	tifying Physic	cian: To the be	st of my knowle	edge, death or	cured at the time, o	date and n	lace and due to	the cause	e) and manne	r an stated	
he Ho in 24 he Fu iplete	Medical	CHECK Z IN INICI	aicai Examin	er: On the basis	or examination	and/or investig	gation, in my opinion ath occurred at the	death occ	curred at the time	a data and r	dage and due	to the equa	a/a) and manney ataked
Voith To t		29b. Signature and title of c)			29c. License r	_			. Date signed		
ann		Mulue	10.	nulo	rul	MA		1666	7		1 - 1	12.	12
221		30. Name and address of p				23a) (Type, Pri	/	,		. /	-	7	
Stat	Α_	Michael 31. Date filed (Month, Day,)	'ear)	32. Rec	istrar's Signatu	(10	medical	1	entro	100	senl	Nun	MO
Registra	.C	JAN 2 3		Questa	J.	barre	D						
D10014=5				contractor of	-	1		_					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Nuzhat Bagar January 16° 2012° 8:38A. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Columbia Howard If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. . Social Security Number 409-85-0503 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign **Funeral** Director 1 □ M 2 🛛 F Pakistan 48 Yrs. Dec. 8.1963 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Director notified Maryland Howard Elkridge 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 and Mental Hygiene. is marked other than "natural", or items 23a or raumatic event, the Medical Examiner must be I Funeral 21075 6141 Downs Ridge Court United States permit. Page 1 and 2 should be filed within 72 hours after death . Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4 on 5+) Elementary/Secondary (0-12) retail sales Associate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Syed Abul Qasim Zaidi Sakina Zaidi Nasir 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sayed H. Bagar -husband 6141 Downs Ridge Court Elkridge, Maryland 21075 item 27 i 20a. Nethod of Disposition

14 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place Md. National Mem. Park b 1/17/2012 Laurel, Maryland injury (4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Bonard WireBorgwardt Funeral Home. PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or computations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ GASTRIC disease or condition resulting in death) CANCE SEPTEMBER 2010 Medical by to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ģ in the past 12 months?
1 ☐ Yes 2 🛣 No
9 ☐ Unknown Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 1 Yes 2 No certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 2 1 ☐ Yes 2 🗶 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6X Other (Specify, 28a. Date of injury (Month, Day, Year) Manner of Death 28c. Injury at work?
1 Yes 2 No 28b. Time of 28d. Describe how injury occurred Certificate: injury 1 X Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fi Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one) 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year)

5 pm

State Registrar DANKUE DOBERMAN, MS 6336

31. Date filed (Month, Day, Year)

JAN 232012 Severy B. Sparker

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CEDAR LANE

JANUARY 16, 2012

COLUMBIA, MD 21044

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ <u>10:</u>00 P^M Miriam Crow1 0.1 06 2012 Medical 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2013 Hopewell Road Port Deposit 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🛣 F Months Days Hours Min (Month, Day, Year) .0/21/193 Country) Director 79 200-24-2003 Usual Residence of Decedent 28a-f shov 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a State 10b. County 10d Inside City Limits Examiner must be notified at Director 1 Yes 2 K No MD Ceci1 Port Deposit 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2013 Hopewell Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Black White etc. þ 1 Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: 3 Widowed 4 Divorced Completed White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the 12 <u>Journalist</u> Newspaper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John Cassel Mabel Riegel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lise Brown - daughter Lafayette Ave. Rising Sun, MD 21911 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1/11/2012 cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State injury or 4 ☐ Donation 5 ☐ Other (Specify) H0me PA Rising Sun. MD ne of Funeral Servi a Lic any inj 22. Name and Address of Facility R.T. Foard Funeral Home, PA 111 S. Queen Street, Rising Sun, MD 21911 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one can that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Examiner It any leading to transclude cause. Enter Underlying Cause (Disease or linjury that initiated events WINZ To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IE EEMALE: IF FEMALE. 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 month Month Day Year Pregnant at time of death signed by the a Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate ha performed Yes 25 1 Yes 2 No 25. Was case referred to medical To the Funeral Director: After this certific completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Other မ 1 Inpatient 2 Z ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Beath 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Yes 2 🗌 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of proknowledge, de ath occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

32. Registrar's Signature

C10004616

Newark De 19802

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2012 Day Jan 2 Physician/ 5:30 A Paul Clayton Cave Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Southern Maryland Hospital Clinton Birthplace (State or Foreign Country) Social Security Number Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day, Year) Maryland **Director** 1 🗓 M 2 🗆 F 70 220 40 5733 Nov 28, 1941 Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State **Funeral Director** 1 Yes 2 No Clinton Maryland Maryland Prince George's 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 20735 10100 Dangerfield Road 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Y Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify. 3 Widowed 4 Divorced Year or Dates.Vietnam 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) 9th College (1-4 or 5+) Auto Body Tech Automotive Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) မ Anna M. Haun William M. Cave 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10100 Dangerfield Road, Clinton, MD 20735 Mary E. Cave (Wife) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 K Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cemetery 1/17/2012 Cheltenham, MD 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Sign Ture of Funeral Service License Ferry Road, Clinton, MD 20735 Plat 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line, Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (a) as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 1 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day Pregnant at time of death 5 Other (specify) signed by the at Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 3 Probably 4 Unknown 2 1 No 1 Yes Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy certificate has performed 1 🗌 Yes 2 🗆 No 1 ☐ Yes 2 ☐ No director. 25. Was case referred to medical 26. Place of Death (Check only one) Be 2 1 No 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify, 1 🗌 Inpatient 2 🗎 ER/Outpatient 3 🗌 DOA မြ within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certificate: injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 🗜 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 01/02/ 20) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

JAN 11 2012 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Day 1. Decedent's Name (First, Middle, Last) Month **Physician** 10:37A M 2012 LIONEL CARROLL January /Medical County, of Death Town, or Location of Death 4c. 4a. Facility Name (If not institution, give street and number) **Examiner** HARL PLATA ENTER MEDICAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, DEC 23, 9. Birthplace (State or Foreign Sex 1**X** M 2□ F 7. Age (In yrs. last birthday) Social Security Number **Funeral** Hours Months Days MARYLAND 214-68-9294 Director Usual Residence of Decedent Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 XYes 2 No Funeral Director NANJEMOY CHARLES MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number UNITED STATES 20662 3140 POSEYTOWN ROAD 12. Was Decedent Ever in U.S. Armed Force ? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: BLACK <u>ک</u> 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) BUILDING SERVICE MANAGER EDUCATION 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HAZEL R. CARROLL COLBERT DENT မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3140 POSEYTOWN ROAD, NANJEMOY, MARYLAND 20662 SHEILA D. CARROLL/WIFE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 KBurial 2 Cremation 3 Removal from State OAK GROVE BAPTIST CH. CFM. JAN 13, 2012 GRAYTON, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) Signature of Euneral Service Licensee
LADIA C. THORNION JOHNSON/MO0583 THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MD 20640 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** liver cance disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b irector, page 2 sl autopsy performed' 1∐Yes 2-⊠No 1 ☐Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12% Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29d. Date signed (Month, Day, Year)

within 2

State Registrar 29b. Signature and title of certifier

Ivel sse

michel, MD

Michel

31. Date filed (Month, Day, Year)
JAN 10 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

5 Garrett Avenue

32. Registrar's Signature

29c. License number

D69566

La Plata, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 7:52am 2012 Thyra Remilekun Viola Carew January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's 15772 Easthaven Court Bowi.e. 7. Age (In yrs. last birthday) If Under Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. Director 578-88-1254 1 🗆 M 2 🗓 F 67 01/17/1944 Sierra Leone Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 X No Prince George's Bowie Maruland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 10 must be Funeral 23a 20716 U.S.A. 15772 East Haven Court filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status "natural", or iten edical Examiner African-American þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 Widowed 4 X Divorced Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Ith and Mental Hygiene.

27 is marked other than "r traumatic event, the Med College (1-4 or 5+) Elementary/Secondary (0-12) Healthcare Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Fanny Weekes permit. Page 1 and 2 should be a Department of Health and Menta Important: If item 27 is markec John Malamah-Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15772 Easthaven Court, Bowie, Maryland 20716 Richard Carew - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 5 01/21/2012 | Silver Spring, MD injury o Gate of Heaven Cem. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. Signature of Funeral Service Licenses 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final disease or condition Ph. sician/ Chronic Kidney Disease - Stage 5 Medical resulting in death) Due to (or as a consequence of) Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) \$ that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Diabetes and Due to (or as a consequence of) Physician/Medical Cardiovascular Accident Box 68760 as IF FEMALE: use 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death for in the past 12 months? Month Day Year Pregnant at time of death g 👿 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Tes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an death? Yes 2 X No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 2 **X** No 1 Yes 4 Nursing Home 5 X Residence 6 Other (Specify 욘 1 Inpatient 2 ER/Outpatient 28b. Time of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending hin 24 hours after death.

the Funeral Director: After a pletely filled in by the fur 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I 29d. Date signed (Month, Dav. Year) 2012 agreen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #302, Riverdale, Maryland 20737 Safia Tasneem, M.D. 5711 Sarvis Avenue, 31. Date filed (Month, Day, Year) State JAN 05 2012

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) 0430 M Physician/ Linda Kay CUNNINGHAM Yunuaru Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington Hagerstown Meritus Medical Center 8. Date of Birth
(Month, Day, Year)
June 14,1948 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Hours Maryland 214-54-0190 63 Director Usual Residence of Decedent 10d. Inside City Limits or 28a-f shov 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No Boonsboro Maryland Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21713 USA items 23a Funeral 141 S. Main Street Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc ò 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates white Specify: "natural", Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) her own home housekeeper Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental Fishers is marked of permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve ဂ္ Thelma Lorraine Smith Herbert Lee Andrews 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18926 Dover Dr., Hagerstown, Maryland 21742 Jeff Pepple - nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery 1/14/12 Signatu Funeral Service Lic MINNICH FUNERAL HOME 22. Name and Address of Facility E.Wilson Blvd., Hagerstown, Md. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myo car die Physician/ -1 140 disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Y EAR UROHMY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) YEARS CONGESTIVE Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last HEMI and Due to (or as a consequence of): attending physician YEMRI Physician/Medical OBSMULTIVE 14 MERSMION Division of Vital Records, P.O. Box 68760 use as IF FEMALE: s, outcome of pregnancy Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Vear 5 Other (specify) Pregnant at time of death 4 ☐ Pregnant : 9 ☐ Unknown sate has been signed by the a page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Dunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No certificate Yes 25. Was case referred to medical completed filled in by the funeral director, To Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 KER Outpatient 3 IDOA After this 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1
Yes 27. Manner of Death 28b. Time of 28d Describe how injury occurred Certificate: 1 🔀 Natural 5 Pending 2 🗌 No 24 hours after death. Funeral Director: Al Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier

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within 24 To the I

Registrar DHMH 17 Rev 7/2009 3 [

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

egistrar's Signatu

An)

29b. Signature and title of

31. Date filed (Mor

ARINA

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

/TAGENIOWSV

29d. Date signed (Month, Day, Year)

License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19a Per FH G925 3/07/2012 JH State of Maryland / Department of Health and Mental Hygiene _ State Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 9 2012 Year Physician/ Edith Mary Carey Jan. 4:30 A^{M} Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Mary's Callaway Hospice Of St. Mary Birthplace (State or Foreign Country) Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day, Min 1 □ M 2 🛛 F Hours Director 228 26 8807 100 191 MD Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits at with the Maryland Director or 28a-f sl 1 XYes 2 No Lexington Park MD St. Mary's 5 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? "natural", or items 23a o edical Examiner must be Funeral 46553 Valley Ct. #6007 20653 USA 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Black 3 ₩ Widowed 4 □ Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natu
any injury or other traumatic event, the Medicall 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Private 7th Cook Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Hopkins Mary Hayden 19a. Informant's Name/Relationship (Type, Print) Granddaughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 46553 Valley Ct.#6008 Lexington PK.,MD20653 <u>Mary</u> Young/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State 1/18/2012 Leonardtown, MD 4 ☐ Donation 5 ☐ Other (Specify) Charles Memorial 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Briscoe-Tonic Funeral Home eximizely purce-1 our 38576 Brett Way Mechanicsville, MD20659 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 2 Physician/ CARCINO MATOSIS RITONEA disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) burial-transit Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 the ! for use as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Day Month Year 1 Yes 2 Unknown detached Division of Vital Records, P.O. by signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown To the Hospital or Attending Physician: The law require within 24 hours after death.

To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should it Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 Residence 6 Stother (Specify) Hostice House မ 1 Inpatient 2 I ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 1 🔀 Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of lertific 29c. License number 29d. Date signed (Month, Day, Year) 68846 ss of person who completed cause of death (Item 23a) (Type, Print) 30. Name and add HOSPITAL, 25500 POINT LOCKOUT ST. MARY'S AMIR RE, LEWARDEUN, MD-20650 KHAN 31. Date filed (Month, Day, Year)

JAN 1 3 2012 State Registrar

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	e filed within 72 hours after death with the Maryland ttal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ral Director	Md 10e. Street and Nur 5 Quiet	own or Loc	10f. Zip	Code			_		10d. Inside City Limits 1X Yes 2 □ No f What Country? alvador						
936	s after death wi al", or items 2 Examiner mus	d by Funeral	11. Marital Status	ried 2 Marrie	12. Was Decedent Armed Forces?			Vas Decede Yes, specif	ent of His fy Cubar		(Specify Yes or No Juerto Rican, etc.)	D-	14. Race - A Black, W	merican Indiar /hite, etc.			
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Baltimore,	permit. Page Department Important: I any injury o		4 Donation 21. Signature of Fu			Gene	22	. Name and	l Address	s of Facility	John T.	Rhin	es Fun		ome 3005		
	hysician/ Medical examiner	al Examiner	short, Enter- short, or hea disease or condition resulting in death) Sequentially list or if any, leading to in cause. Enter Unde Cause (Disease or that initiated event resulting in death)	rt failure. List onl (Final on anditions, nmediate rlying injury s	b. Due to (or as	Due to (or as a consequence of): Due to (or as a consequence of): O SepSis								Interval Between Onset and Death Days Days Days			
P.O. Box 68760	nat the death certificate be exed by the attending physician detached for use as the buria	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1								1/12	113	23d. Date of Month	,			
ords, P.O.	requires the been signal should be	Traumatic Brain injury, Seizure, Diabetes								Yes 2	ØNo 3□	e to the cause Probably 4 autopsy findir	Unknown				
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Division of Vital Records,	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director. After this certificate has completely filled in by the funeral director, page 2.	al Certificate:	2 XAccident 3 ☐ Suicide 4 ☐ Homicide	Investigat 6 Could no determine	t be	ury - At home c. <i>(Specify)</i>	9:1			∕es 2XINo	28f. Location	(Street ar	nd Number or	Rural Route No	umber,		
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	(Check 2	☐ Medical Exa ☐ Certifying N	hysician: To the best of miner: On the basis of e urse Practitioner: To th	examination an	id/or investi	gation, in m death occur	y opinior	n, death occur e time, date ar	ce, and due to the red at the time, date	cause(s) a e and place o the cause	and manner as e, and due to t e(s) and manne	s stated. he cause(s) and	I manner stated.		
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Please Type or Print in Black Indelible Ipk, Ensure All Copies Are Legible.
Amend 24a per med cert G924 2/3/12 dk
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Physician 0530 2012 5, Jan. George Wayne Cross /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Somerset Marion Station 4056 Back Shelltown Road Under 1 Year | If Under 24 Hrs. onths | Days | Hours | Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 1 M 2 □ F Age (In vrs. last birthday) **Funeral** Months Yrs. Maryland Mar. 11, 1950 61 Director 216-52-3986 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or Items 23a or 28a-f show the M-dLal Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Marion Station Marvland Somerset 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S. 21838 4056 Back Shelltown Road Funeral death 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any Injury or other traumotto. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Heavy Equipment Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hazel Wyatt George Oliver Cross ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Janet Cross Wife 4056 Back Shelltown Rd., Marion Station, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cross Family Cemetery 01-08-12 Marion Station, Md. 21. Signatura of Funeral Service Licensee 22. Name and Address of Facility Hinman Funeral Home 21853 M00295 11673 Somerset Ave., Prince 23a. P. J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or res, ratory arrest, pack, or heart failure. List only one cause on each line. MO0295 11673 Somerset Ave., Princess Anne, Md. Approximate Interval Between Onset and Death Impedate Cause (Final di earle or condition raciting in death) 1 **Physician** /Medical Due to (or as a consequence of): > 6 month Examiner Meb. 61 E squer hally flat conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine be executed and Due to (or as a consequence of): attending physician Box 68760 Physician/Medical law requires that the death certificate IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) the Ö 9□Unknown 9 Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Records, obably 4 □Unknown 1 Yes 2 No page 2 should Completed been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed The 2 🗆 No le n 1□ Yes 2☐No 1 ☐ Yes Division or Vital or Attending Physician: 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 \sum Nursing Home 1 Tes 200 2 ☐ ER/Outpatient 3 ☐ DOA Fesidence 6 ☐ Other (Specify) Certification: To this 28a. Date of Injury (Month, Day Year) Manner of eath 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No Director: 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide Hospital Funeral 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Check only Medical one) the within To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2 ll ms erson who completed cause of death (Item 23a) (Type, Print) 30. Name and all et, Suite 105 hittake lent 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 3. Time of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 1:09P M 2012 Ja<u>nuary</u> Patricia Elaine Critchlow Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring Holy Cross Hospital 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** Days Hours **Director** 213-08-4130 1 M 2 😾 F 86 Yrs 05/04/1925 Guyana ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10b. County 10c. City Town or Location 10a. State Director 1 🗆 Yes 2 😾 No Maryland Prince George Brentwood 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number "natural", or items 23a Funeral 20722 U.S.A 3416 41st Avenue death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Examiner Black, White, etc. 1 Never Married 2 Married ☐ Yes 2**X** No Yes, Give þ 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Specify: 3

Widowed 4 □ Divorced Completed Black Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than " Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. Domestic Homemaker is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Amy Lamason Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3416 41st Avenue Brentwood, MD 20722 Jennifer Critchlow/Daughter f Health item 27 i injury or other 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of H Important: If ite any injury or oth 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 01/14/2012 Brentwood, MD 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funeral Service Licens 3401 Bladensburg Rd. Brentwood, MD 20722 a. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Months disease or condition Congestive Heart Failure Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Exami Cause (Disease or injury that initiated events requires that the death certificate be executed and -trar Due to (or as a consequence of): resulting in death) Last burial physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Dav Year Pregnant at time of death 2 X No 9 Unknown Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😾 Unknown Hypertension Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Diabetes Mellitus autopsy certificate has performed? 1 Yes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Yes 2 🔀 No ္ရ 1 Inpatient 2X ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 X Natural 5 Pending ☐ Accident ☐ Suicide Investigation filled in by the 3 Suicide
4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office determined after building, etc. (Specify) within 24 hours a x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) No 01/10/2012 D28656 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ravi Passi, MD 15245 Shady Grove Rd. #130 Rockville, MD 20850 JAN 1 2 2012

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Year 2310 Crabtree Donald Elwood ZOI Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death WHMS-RMC Allegany Cumberland Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country MD ^{ear}1<u>926</u> Months Davs Hours Min. Sep 22. 1 XM 2 🗆 F Director 220-26-7593 85 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits the Maryland Examiner must be notified at Director MD Cumberland Allegany 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 23a or 10g. Citizen of What Country? **Funeral** I Page 1 and 2 should be filed within 72 hours after death with 21502 701 E. 4th Street Apt. 201 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Forces? Black, White, etc. Completed by ō 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give "natural" 3 Widowed 4 Divorced WW II white Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) ed other than " event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) Health and Mental Hygiene. Celanese Corp doffer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary E. Hott Gilbert W. Crabtree 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 701 E. 4th St. Apt. 201 Cumberland MD 21502 **Grace Crabtree** wife item 2 20b. Place of Disposition (Name of cemetery, crematory or other place)
Rocky Gap Veterans Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1
Department of
Important: If it
any injury or o ment of 1 X Burial 2 Cremation 3 Removal from State 1/13/2012 MD Flintstone 4 Denation 5 Other (\$pecify) Sonature f Filmeral Service 22. Name and Address of Facility ral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Part 1. Inter the disease, or complications that caused shock, or heart failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1 Approximate Interval Between Onset and Death Immediate Cause (Final CARDIAC Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** FIBRILLATION NTRICULAR Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury anding physician and use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Fctopic pregnancy in the past 12 months?
1 Yes 2 No for 5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 been signed by the should be detached g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? page 2 2 🗌 No 1 Yes Be 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No ၉ 1 Inpatient 2 ER/Outpatient 3 I DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniurv 1. Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after deat Funeral Director, 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) the withir To th 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OORE, M.D. 1/3/17 D7228 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)
JAN 17 2012

M.D.

32. Registrar's Signature

12500 WILLOW BROOK

Rel.

CUMBERLAND IMD 21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Clites Gerald Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Allegany Cumberland WMHS-RMC If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Birthpia PA Hours Dec 23 ^a1943 Director 201-38-9416 1 XM 2 □ F 68 Usual Residence of Decedent 28a-f show 10a. State notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Allegany Cumberland 1 XYes 2 No 10e. Street and Number 10f. Zip Code or 10g. Citizen of What Country? nit. Page 1 and 2 should be filed within 72 hours after death with the artment of Health and Mental Hygiene.

ortant; If item 27 is marked other than "natural", or items 23a or injury or other traumatic event, the Medical Examiner must be a Funeral USA 517 Pine Avenue 21502 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates Specify. 3 Widowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 10 Carpentry carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, permit. Page 1 and 2 should be Department of Health and Ment. Important; If item 27 is marked any injury or access. ည Ruth Scott Ambrose Clites 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 517 Pine Avenue Cumberland MD 21502 Mary Clites wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Sunset Memorial Park Cumberland MD Donation 5 Other (Specify) f Funeral Service L 22. Name and Address of Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Buter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, of heart failure. List only one cause on shock inc. Approximate Interval Between Onser and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions Examine ri any, leaving to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence on The law requires that the death certificate be executed tranand that initiated events resulting in death) Last Due to (or as a consequence of): physician ar Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day Year Unknown 9 🗌 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has performe death? 2 🗌 No Yes 2 Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 \(\text{Yes} \) Other: ျပ 1 Inpatient 2 ER/Outpatient 3 I 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director; After to ompletely filled in by the funer 1 Natural 5 Pending work 1 Yes 2 No ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier Registrar's Signature State 2 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Registra/Imend#4bPerPhys.&10cPerFHPQC1-19-12cCertificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Beves 0417AM 2012 Medical Tanvara 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Clinton Southern Maryland Hospital Forestville Prince Georges . Age (In yrs. last birthday) **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year) Days 410-17-6751 Months Hours **Director** 1 🗆 M 2 🛣 F 49 06/70/7465 OH Usual Residence of Deceden 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Forestville Prince Georges Foretsville 1 X Yes 2 No 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 2110 Brooks Dr._apt. 310 20747 AZU 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. Armed Forces 0 þ 1 Never Married 2 X Married 2 X No 1 Yes : Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced Specify: Black Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the White House Comm. Specialist Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be 1.
Department of Health and Mental. Important: If item 27 is mediany injury or other? ဂ္ Ralph Davis Corrine Jessica Newsome 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martin Canery Jr. / husband 2110 Brooks Dr., apt. 310, Forestville, MD 20747 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery 01/13/2012 | Clinton, MD 21. Signatur of uneral Service Lice 22. Name and Address of Facility Strickland Funeral Services 6500 Allentown Rd., Camp Springs, MD 20748 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) Acule Myclardia 2wnds Medical Due to (or as a consequence of) Examiner Core(bu/monen Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed -tran and that initiated events resulting in death) Last Due to (or as a consequence of): burialphysician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months 3 Ectopic pregnancy
5 Other (specify) ō Day Pregnant at time of death Month Vear Unknown 9 Unknown ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by pe page 2 should Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Jas autopsy performed death? certificate I Yes 2 No 1 Yes 2 No eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No မ Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Mann of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 1 🗌 Yes Suicide 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00008 207 mo 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar KellA

Surlatts

7503

32. Regisar's Sig

Rough

21785

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep		Mental Hygiene	2012 01648							
	_		Registrar 1. Decedent's Name (First, Middle, Last)	rtificate of Death	Reg. No.	3. Time of Death							
	Physicia				Month Day January 12.	Year							
Ser.	Medio Examin		Mary Regina Carrol1 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		County of Death							
not the			The Woods of Sun Valley	Westminster		Carroll							
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	Birthplace (State or Foreign Country)							
	Director		223-36-7397		09/25/1925	Maryland							
	show d at	ō	10a. State 10b. County 10c. City, Town or Lo	cation		10d. Inside City Limits							
	Maryli 28a-f etifiec	Director	MD Carroll Westm:	inster		1 ☐ Yes 2 🔀 No							
	a or a	iO le	10e. Street and Number	10f. Zip Code	,	en of What Country?							
	th with mrs 23 must	Funeral	3840 Ridge Road	21157		ited States							
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2-0	within 72 hours after death with the Maryland gleine. et than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at the Medical Examiner.	Completed		dent's Usual Occupation kind of work done during most of work	ing 16b. Kin	d of Business/Industry							
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Baltimore, Maryland 21215-0036	should be file n and Mental H 7 is marked o raumatic eve			ng Address (Street and Number or Rur									
Σ	and 2 s Health a tem 27 i			40 Ridge Road, Wes	stminster, M	D 21157							
ore	pe 1 ay t of H If ite or oth			matory or other place)		cation - City or Town, State							
Ħ.	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Martal Hygiens. Important: If item 22 a or 28a-f s in marked other than "natural", or items 23a or 28a-f s any injury or other traumatic event, the Medical Examiner must be notified once.		4 □ Donation 5 □ Other (Specify) St. Jose	phs Cemetery 01/18		keystown, MD							
Bal	permit. Page 1 a Department of F Important: If ite any injury or of once.	21. Signature of Funeral Service Licensee MO1222 Name and Address of Facility Keeney & Basford Funeral Service Licensee MO1222 To E. Church St., Frederick, MD 21											
			23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between							
*	h sician/		Immediate Cause (Final disease or condition resulting in death)	Diserie		Onset and Death							
	Medical Examiner		Due to (or as a consequence of):										
18	100	ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):										
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687	ertific Iding p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		2	3d. Date of delivery							
Вох	eath c atten	iciai	in the past 12 months? 1 Yes 2 No. 1 Pregnant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)		Month Day Year							
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Vita	ysicia s certi direct	To Be	examiner? 1 ☐ Yes 2 ☒ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie			Assisted Living Other (Specify)							
of	ng Phy ter thi neral		27. Manner of Death 28a. Date of injury 28b. Time of		28d. Describe how injury								
on	tendir eath. or: Af the fu	ifica	2 Accident Investigation	M 1 ☐ Yes 2 ☐ No									
Division of Vital Records,	or Att after d Direct in by	Certificate:	4 Homicide determined 28e. Place of Injury - At home, farm, sti	reet, factory, office	28f. Location (Street and City or Town, State)	Number or Rural Route Number,							
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1 K. Certifying Physician: To the best of my knowledge, death	occurred at the time, date and place, a	and due to the cause(s) and	d manner as stated.							
	ne Ho n 24 h ne Fur pletely	Medical	(Check 2 Medical Examiner: On the basis of examination and/or investonly one) 3 Certifying Nurse Practitioner: To the best of my knowledge	stigation, in my opinion, death occurred a	t the time, date and place,	and due to the cause(s) and manner stated.							
	Voithi Voithi Comp	_	29b. Signature and title of certifier	29c. License number		e signed (Month, Day, Year)							
	Vince	Bolok many De H53939 Jan 17, 2012											
	1014		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Babak Imangel, Do; 218 bashing he Heights Med Ctr; we strainster, MD 21157										
	Stat	e	31. Date filed (Month, Day, Year) 32. Registrar's Signature	743 1144 (11) 10(3)	, , ,	<u> </u>							
	Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Physician/ 8:50 2012 STEPHEN JOSEPH DOHERTY Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner comic HOSpice If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours DECEMBER 29,1952
MASSACHUSETTS **Director** 023-44-0091 1 🕅 M 2 🗆 F 59 Usual Residence of Decede "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2X No MARYLAND WORCESTER WHALEYVILLE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funera 11939 BLUEBERRY ROAD 21872 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married ò 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates. Specify: WHITE Completed 3 Widowed 4 Divorced altimore, Maryland 21215-000 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) COLLECTION MANAGER Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 JOSEPH DOHERTY RITA SULLIVAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LINDA J. DOHERTY/WIFE WHALEYVILLE, MARYLAND 21872 11939 BLUEBERRY RD., 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) DALE CEMETERY 1/9/12 WHALEYVILLE, MD Funeral Service Lide 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE 19975 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final BRAIN Ph_sician/ a MALIGNANT disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buris Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Year Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown signed by the at Id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ᇫ 2/ No Division of Vital Records, 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has I performed autopsy Yes 2 10 this certificate funeral director, 25. Was case referred to medical 26, Place of Death (Check only one) Be examiner? 4 Nursing Home 5 Residence of Other (Specify) HCSPILIZ 1 🗌 Yes 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After t completely filled in by the funeral Natural iniury work?
1 ☐ Yes 2 ☐ No 5 Pending 2 Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 [only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DO05 8460 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1300 33 6 Haison 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 0 6 Registrar

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		-	For State Registrar		Sta	ate of IVI	arylan		artme <i>rtifica</i> :			and iv	lental Hy	/giene Reg. N	001	2 (11650)
	Physicia	n/	1. Decedent's Name			r.				- 12 . A			2. Date of D				Time of Death	
3 40	Medic	al	4a. Facility Name (if			CAME	FUI	340			Location	of Death	LAL	<u> </u>	County of De		6:56 PM	_
mote	Examin	er	Suburba		ing marrison)	la	Death											
H	Funeral Director		5. Social Security Nu None	umber	6. Sex	"	e (In yrs. Ia	ast birthday)	If Unde Months	Days	If Under Hours	Min.	8. Date of Bi (Month, D	ay, Year)	9. Birthplace (State or Forei Country)			
	3		Usual Residence o		1 1 1 2		55	Yrs.					Feb. 1	8, 1	946 I	aly		4
	aryland a-f sho fied at	ector	10a. State	10b. County	omery			, Town <i>o</i> r Lo Rockví									side City Limits Yes 2 No	
	the M a or 28 be noti	Funeral Director	10e. Street and Num		Omery			COCKVI		p Code				10g. C	itizen of What	Country?		_
	th with ms 23; must	ınera	4657 Che	rry Va				140	Mar Dane	208		-i-2 (C	if . Van av Na		Venezue		P	-
9036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed by Fu	11. Marital Status1 Never Marri3 Widowed		ied 1 [as Decedent med Forces? Yes 2XX fes, Give ar or Dates.		- 1					cify Yes or No Rican, etc.) uelan		14. Race - Ar Black, Wl Specify: Wh	nite, etc.	nan, 	
15-0	72 hou "natu ledical	nplet	(Spec	15. Deceden cify only highe				16a. Dece (Give	dent's Usi kind of we	ork done a	ation luning mosi	t of workir	ng	16b. l	Kind of Busine	ss/Industry		
212	giene. er thar	Con	Elementary/Seco	ondary (0-12) 9	Co	llege (1-4 or	5+)		riet					Ow	m Busi	ness	_	
Maryland 21215-0036	ld be filed wental Hygiarked other	To Be	17. Father's Name (F		,								(First, Middle De F11					
Mar	2 shouth and the and the strain t		19a. Informant's Na Maria Do				ife		-	,					r Town, State,		553	
Baltimore,	of Hea		20a. Method of Disp	osition			20b. P	lace of Dispo	osition (Na	me of		0	ate	т	ocation - City			_
tim	permit. Page 1 a Department of H Important: If ite any injury or ot		4 Donation	5 Other (S	pecify)	rai from State		ropoli	tan (rema	tory	Jan. 2			xandria			
Bal	permit. Departr Importa any inji		21. Signature of Fur	neral Service L	censee	foto	Moi:								me Inc.		MD 20901	
et	Physician/		23a. Part 1. Enter the shock, or hear Immediate Cause (I disease or condition	t failure. List <i>o</i> Final	nly one caus		d the death		er the mo	de of dying	g, such as	cardiac o				Appi Inter Onse	roximate val Between et and Death	
	Medical Examiner		resulting in death)		a	Due to (or as					I l-							_
	pe h	Examiner	Sequentially list cor if any, leading to im cause. Enter Under Cause (Disease or i	imediate	b	Due to (or as	a cons eq u	ence of):										
0	s be executed ysician and e burial-tra	اجا	that initiated events resulting in death) L		c	Due to (or as	a consequ	ence of):										
68760	ath certificate be attending physici for use as the bu	/Med	IF FEMALE:		220 If s	es, outcome	of progna	nev										
Box	de de	by Physician/Medica	23b. Was decedent in the past 12 n 1 Yes 2 2 9 Unknown	nonths?	1 4	Live Birth Pregnant a	2 Feta	I death 3	Ectopic Other (s		y				23d. Date of Month	delivery Day	Year	
ds, P.O.	requires that the been signed by the should be detach	ted by P	Part II. Other signifi	icant conditio	ns contributi	ing to death t	out not res	ulting in the	underlying	cause giv	en in Part	l. 			use contribute		use of death?	
Division of Vital Records,		Completed											24a. Was auto per 1 🗆 Yes	s an opsy formed? 2	prior	to complet	ndings available ion of cause of No	
/ital	sician; certific irector,	Be	25. Was case referre examiner?	ed to medical	Hospita	l: .\=n				Othe	ace of Dea							_
on of V	the Hospital or Attending Physician: The law Inin 24 hours after death. The Funeral Director. After this certificate has mpletely filled in by the funeral director, page 2	cate: To	27. Manner of Death 1 Natural 2 Accident		g	a. Date of inju	iry	ER/Outpatie 28b. Time o injury		28c. Injury work	4 L∐ Nu ⁄at	. 2	me 5 ∐ Res 28d. Describe		6 Other (Sp ry occurred	ecify)		
Divisio	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Il Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could determine	not be	e. Place of Inj building, et			reet, facto	ry, office			28f. Location City or To		nd Number or e)	Rural Route	e Number,	
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical	(Check 2 only one) 3	☐ Medical E☐ Certifying	kaminer: On	the basis of e	xamination	and/or inves	stigation, Ir , death oc	my opinic curred at ti	on, death oo he time, da	ccurred at	the time, date	and place the caus	e(s) and manne	ne cause(s) er as stated		d.
	2 5 2 5		29b. Signature and t	till	~					c. License	number 46	75		29d. D	ate signed (Mo	nth, Day, Y	(ear)	
_			30. Name and eddre	B o	vho complete	ed cause of c	eath (Item	23a) (Type, I	Print)	h.	BETH	ES DA	in.	AM	yland P			
	Sta Registra	e	31. Date filed (Month			-73	ar's Signat	8. 4	ali	0,			/		t .			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ 2:30AM 61 -2012 William E. Donaway 03 Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Salis burg Wicomico Coastal Hospice at Lake the 1 Year If Under 24 Hrs Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Days Hours Min Director 216-40-3772
Usual Residence of Decedent 1 **X** M 2 □ F Yrs 69 Oct. 27, 1942 Maryland 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director notified 1 Yes 2 X No MD Wicomico Willards 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ы items 23a or ner must be n Funeral 21874 U.S.A. 35869 E. Line Road 12. Was Decedent Ever in U.S.

Armed Forces?

1 ★ Yes 2 □ No 1960If Yes, Give Year or Dates. 1964 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status ıral", or iten I Examiner ı Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2X No Specify: Specify "natural", Completed 3 Widowed 4 Divorced white Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore, Maryland 2121 Elementary/Secondary (0-12) College (1-4 or 5+) the Automobiles h and Mental Hygien 7 is marked other th 12 Auto Mechanic traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Page 1 and 2 should be f nent of Health and Menta ant: If item 27 is marked Joshua William Donaway Eunice White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Wife) Joan Marie Donaway 35869 E. Line Road Willards, MD William 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State = 5 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Important: If any injury or once, 4 Donation 5 Other (Specify) Cemetery Jan. 7, 2012 Willards, Maryland Bethel Signature of Funeral Service Licensee Name and Address of Facilit Short Funeral 13 East Grove Home Street Delmar, DE 23a. Part 1 shock Enter the disease or como lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate or he art failure. Interval Betweer Onset and Death Immediate Cause (Final CARCINOUN Physician/ LUNG MALIGNANT disease or condition resulting in death) Medical Due to (or as a consequence of). Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed use as the burial-trar and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death signed by the Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 1 Yes 2 No 3 Probably Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has Yes 2 CH 1 🗌 Yes funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury Matural 5 Pending 1 Yes 2 No Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined building, etc. (Specify) City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier

State Registrar DHMH 17 Rev 06-2011

completely

29b. Signature and title of certifie

a Huisan

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WARY

JANO6

Po

32. Registrar's Signature

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year,

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year Physician/ 7:06 PM Scarlet 2012 Dunn Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Baltimore of Maryland Medical Center University If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🕱 F Months Hours lo8%31777982 29 DC 219-06-1652 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important, if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director MD Waldorf 1 ¥ Yes 2 □ No Charles 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral US 20601 2167 Briarwood Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Black Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) Private Specialist Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Beauty Suber Clyde Dunn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1815 Nova Ave, Capitol Heights, MD 20743 Beauty Dunn/ Mother 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Harmony Memorial Park 1-14-2012 Landover, MD 4 Donation 5 Other (Specify Pope Funeral Homes, P.A. 22. Name and Address of Facility Signature of Funeral Service Li 5538 Marlboro Pike, Forestville, MD 20747 MOIDER Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pulmonary Physician/ pderna disease or condition Medical resulting in death) Due to (or as a consequence of : **Examiner** Motastati and losures ma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Year Month 5 Other (specify) Pregnant at time of death signed by the a g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy has performed? 1 Yes 2 No page 1 Yes 2 No After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 💢 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA မ To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 28a. Date of injury (Month, Day, Year) 28b. Time of 28c, Injury at work? 1 ☐ Yes 27. Manner of Death Certificate: 28d. Describe how injury occurred iniury 1 X Natural 5 Pending 2 🗌 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

cR3

State Registrar 22 S. Greene St

Bultmore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regis rar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JANUARY Day₄ 201'2 11:42 PM KELLY LENORE DONNELLY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY NATIONAL INSTITUTES OF HEALTH BETHESDA 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 10/25/1978 Days Hours Min. 1 DM 2 🛣 F 33 092-62-9008 Director Usual Residence of Decedent 10a, State 10b. County the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 ☐ Yes 2X No NY Tioga Nichols 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code items 23a Funeral 1241 Smith Creek Road 13812 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ò 1 Never Married 2 Married \$ Maryland 21215-0036 hours after 1 ☐ Yes 2√☐ No Specify. Specify: White "natural", 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Private Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) e 1 and 2 should be filed of Health and Mental H If item 27 is marked ot or other traumatic even <u>Terrance Brown</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Andrew Donnelly/ Husband Smith Creek Road, Nichols, NY 13812 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1-9-2012 Tioga Cemetery Owego, NY . Signa re of Funeral Service 22. Name and Address of Facility Pope Funeral Homes, P.A. 10108 5538 Marlboro Pike, Forestville, MD 20747 runc Ham 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Set and Reath Physician/ MULTI-ORGAN FAILURE disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** 3 WEEKS CYTOKINE STORM Sequentially list conditions, Examine Due to (or as a consequence of) If any, leading to immediate cause. Enter Underlying or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events 8 YEARS METASTATIC MELANOMA and-trar Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown P.O. been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autonsv performed death? certificate X Yes 2 No 1 Yes 2 X No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 은 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) OREGON MD 153941 JANUARY 5, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15

Registrar
DHMH 17 Rev 7/2009

State

ASHLEY A. STEWART

32. Registrer's Sign

10 CENTER DRIVE, BETHESDA,

MARYLAND 20892

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Voar Jerilyn Αм Divens 2012 :20 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 603 Forest Drive Fruitland Wicomico If Under 24 Hrs Hours Min Birthplace (State or Foreign Country) . Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday, Funeral Days Months Min. 1-15-1952 1 M 2 XF Director 394-54-5634 Wisconsin 59 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 X Yes 2 □ No Wicomico Fruitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 Funeral items 23a USA 603 Forest Drive 21826 within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11 Marital Status Armed Forces? Black, White, etc. "natural", or þ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White 3 Divorced 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Salesperson Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ pe Dona1d Seversen Caro1 permit. Page 1 and 2 should t Department of Health and Me Important: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Divens - Husband Forest Drive, Fruitland, Maryland 21826 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State injury or Crematory of Delmarva:1-9-2012 4 Donation 5 Other (Specify) Delmar, Delaware ature of Funeral Service Licensee 22. Name and Address of Facility Bounds Funeral Home 21 arriver 705 E. Main Street, Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ARDIAC YSRHYTHMIA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner INF ARCTION Acu 76 Sequentially list conditions, Examine if any, isaging to immediate cause. Enter Underlying Cause (Disease or iinjury Ducito for as a sonsequence of: sician and burial-transit death certificate be executed (CRONARY that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown ed by the a detached f 9 | Ilnknown Division of Vital Records, P.O. Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed b 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes been signatures should be 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b irector, page 2 si autopsy performed Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) funeral director, Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Mannér of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After work? iniury 1 🗹 Natural 5 Pending Accident Investigation within 24 hours after death

To the Funeral Director: \
completed filled in by the t 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one 29b. Signature and title of certific 29c. License numbe 29d. Date signed (Month, Day, Year) 38647 01-06-2012 M

210

State Registrar 21804

30. Napre and address of person who completed cause of death (Item 23a) (Type, Print)

32.

egistrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month helma 2012 11:31 P^M Jaunary Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Birchwood Group Home Oxon Hill Prince Georges Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Months Days Hours 219-18-4295 **Director** 1 🗆 M 2 😿 F 92 Sept. 12, 1919 Maryland Usual Residence of Decede or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Marvland Prince Georges 1 Yes 2 X No Oxon Hi 11 10e. Street and Number ortant: If item 27 is marked other than "natural", or items 23a or injury or other traumatic event, the Medical Examiner must be n 10f. Zip Code 10g. Citizen of What Country? Funeral 1602 Jarvis Ave. 20745 U.S.A 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. by 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2XX No Specify. Specify: White 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Laundry/Cleaners 12 Secretary and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Nicholas Jenkins Tayman permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Julia Windsor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melvin G. Tayman (Nephew) 5018 Plata St. Clinton, MD 20735 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2 XXCremation 3 ☐ Removal from State Clinton. MD 4 ☐ Donation 5 ☐ Other (Specify) Lee Crematory 21. Signature of Funeral Service Licensee MO1555 22. Name and Address of Facility Lee Funeral Home, Inc. less? 6633 Old Alexandria Ferry Rd. Clinton, MD 20735 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Cardiopulmenary disease or condition Medical resulting in death) Examiner week Sequentially list conditions, it ally leading to in reclaim cause. Enter Underlying Examiner with Dementia the burial-transi Disease Cause (Disease or injury that initiated events and resulting in death) Last physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death be detached a I Inknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Advanced pementia 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Decubitti - Stage multiple 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 auton malnutrition Protein certificate Yes 2 No 2 No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA Other (Sp 4 Nursing Home 5 Residence After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending injury after death filled in by the 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a To the Hospital Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practity of Err. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of ce MD D0032654 2017

State Registrar 30. Name and address of p

31. Date filed (*Month*, *Day*, *Year*)

JAN 1 1 2012

John

2033

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Serlamitsos

21032

Penderbrooke Dr. Crownsville, mD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 2 State
Registrar Certificate of Death Reg. No. SERVICE Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DAYE 5:40 AM BERNICE JANUARY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CHARLES CIVISTA MEDICAL CENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** Days Months Hours MAY 10 4 1933 1 M 2 F MARYLAND 78 Director 217-32-1268 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County Director 1 Yes 2 X No MARYLAND **CHARLES** INDIAN HEAD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral UNITED STATES 20640 5520 CHICAMUXEN ROAD 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: If Yes, Give 3 Widowed 4 Divorced BLACK Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) SOCIAL SERVICES NUTRITIONIST 12TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MARY ELIZABETH FRANKLIN LINKINS GEORGE LAWSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh
Department of Health al
Important: If item 27 is
any injury or other trau 7830 CONTEE ROAD, APT.330, LAUREL, MARYLAND 20707 JAMARRA T. MITCHELL / NIECE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) MT. HOPE CHURCH CEM. JAN. 14, 2012 NANJEMOY, MARYLAND 21. Si a fure of Funeral Service Los de THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 LYDIA C. THORNTON JOHNSON MO0583 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last and burial-Physician/Medical certificate be 68760 attending properties for use as IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month 5 Other (specify) Pregnant at time of death the P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions cont þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has 1 ☐ Yes 2 ☐ No this certificate 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) pital:
1 Inpatient 2 ER/Outpatient 3 DOA
28a. Date of injury 28b. Time of 28c မ To the Hospital or Attending Physiwithin 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director. 27, Manner of Death 1 Natural 28c. Injury at work? 28d. Describe how injury occurred Certificate: (Month, Day, Year) 5 Pending 1 Yes 2 No Investigation Could not be Accident 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, 29c. License number 29b. Signature an 30. Name and address of person who co eleted cause of death (Item 23a) (Type, Print) CENNA MEDICAL CENTER 1-C POST OFFICE RD. WALDORF, MD 20602 ABBAS A. OMAIS M.D. 31. Date filed (Month, Day, Year) 32. Degistrar's Signature State JAN11 Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicic completed filled in by the funeral director, page 2 should be detached for use as the bu	Medical			Physician: To the be										d manage state 1
the Ho	Mec	only one) 3	Certifying	Examiner: On the basis Nurse Practioner: To			dge, death oc	curred at the	e time, date and pla		e cause(s) an	d manner as	s stated.	
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(Q)		30. Name and addre	ess of person	who completed cause	of death (Iter	n 23a) (Ty	pe, Print)	15	185	. 0	unic	any		MD
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	Funeral Director		5. Social Security Nu.	5695	7. Age	e (In yrs. last 48	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Dat 9 / 28	place (State try) DC	o <i>r Foreig</i> n			
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21215-0036	s filed within 72 hours after death with the Maryland tal Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Š	11. Marital Status1 ☐ Never Marrie3 ☒ Widowed	ed 2 Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 X If Yes, Give Year or Dates.			Vas Decedent of Hisp f Yes, specify Cuban, ☐ Yes 2 🙀 No	, Mexican, Puerto	ecify Yes or No- Rican, etc.)		e - Americ k, White, e Whi	etc.		
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nor	ige 1 and intof H		20a. Method of Disp 1 Durial 2	Cremation 3 🗆 F	Removal from State	cem	etery, cren	sition (Name of natory or other place))	Date	20c. Location -	•			
Baltimore,	permit. Page 1 and 2 Department of Health Important: If item 23 any injury or other t		4 ☐ Donation 21. Signature of Fan	5 Other (Specify)		Che		ake Crem							
ä	permi Depar Impor any ir		21. Signature of Fangral Service Licensee 22. Name and Address of Facility Raymond—Wood F. PO Box 430, Dunkirk, MD 20754 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,												
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Box 68		Physician/M	IF FEMALE: 23b. Was decedent p in the past 12 m 1 Yes 2 4 9 Unknown	onths?	3c. If yes, outcome of 1 Live Birth 4 Pregnant at 9 Unknown	2 🗌 Fetal de	eath 3 🗔	Ectopic pregnancy Other (specify)			23d. Date of delivery Month Day Year				
P.0	that the ned by a detaction	y Pł	Part II. Other signific				_		n in Part I.	23e. Did to	bacco use contr	ibute to th	e cause of o	death?	
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ita	sician certifi rector	m	25. Was case referred examiner? 1 Yes 2	177	ospital:			Other	e of Death (Chec				_		
ر کو	g Physer this eral di	e: 10	27. Manner of Death		28a. Date of injur		Outpatien b. Time of	t 3 DOA 28c. Injury a	4 ☐ Nursing Ho		ence 6 🗌 Othe				
uo .	ath. r: Afte re fun	icat	1 Natural 2 Accident	5 Pending Investigation	(Month, Day	, Year)	injury	work?	es 2□No		on injury occurre				
Division of Vital Records, P.O.	al or Atte s after de al Directo ed in by th	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Inju building, etc		, farm, stre	et, factory, office		28f. Location (S City or Tow	treet and Numbe n, State)	r or Rural	Route Numi	ber,	
_	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s	Medical	(Check 2	Certifying Physic Medical Examine Certifying Nurse	er: On the basis of ex	amination an	d/or invest	igation, in my opinion,	death occurred a	t the time, date ar	nd place, and due	to the cau	se(s) and ma	anner stated.	
	North Con		29b. Signature and ti	tle of certifier	-0.8	1400	na	29c. License n	100653	3	29d. Date signed				
	in		30. Name and addres	4						SUYO			,		
	4		5857	Deale	2. Chur	ohh		Road				757			
State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature August 1. Sauces August 2. Sauces Augus															

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle Last) Charles 2. Date of Death 3. Time of Death Month Day Year **Physician** 7:35 м ames 2012 06 unuari /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign PA^{untry)} If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Months Days Hours Min. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City. Town or Location 10a. State 10h County MD Baltimore Dundalk 1 Yes 2 □ No Director 10g. Citizen of What Country? United States 10e. Street and Number 6725 Railway Avenue Funeral 12. Was Decedent Ever in U.S. Arged Forces?
1 ⚠ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Glive kind of work done during most of working life. DO NOT use retired)
Security Guard Warehouse Elementary/Secondary (0-12) College (1-4 or 5+) 12 18. Mother's Name (First, Middle, Maiden Surname)
Josephine Helicus 17. Father's Name (First, Middle, Last)
Claude Decker Be ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 18713 Amstutz Rd. Auburn, IN 46706 19a. Informant's Name/Relationship (Type. Print) Alana Smith 20b. Place of Disposition (Name of cametery, crematory or other place)
Med Cure Inc. 20a. Method of Disposition Date 20c. Location - City or Town, State Cumberland, RI 1 Burial 2 Cremation 3 Removal from State 1/13/12 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gerald N. Minnich Funeral 305 N. Potomac St. Hagerstown, MD 21740 Minnich Funeral Home 21. Signature of Funeral Service Licensee M01613 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Depsis /Medical Due to lor as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): attending physician and d for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u></u> Records, 1 🗌 Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Chronic Kidny disease Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 🗌 Yes 2 🗌 No 1 🗌 Yes 2 No certificate Division of Vital or Attending Physician; 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 ☐ Yes 2 No 1 XInpatient 3 DOA 2 ER/Outpatient Certification: To Director: After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 Natural 1 Yes 2 No 2 Accident Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide hours within 24 hours a the Hospitai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c, License numbe 29d. Date signed (Month, Day, Year) D71510 Januaryo MICHAEL THOMAS WO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IW-Z 4940 Eastern Avenue, Baltimore, MD, 21224 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State

DHMH 17 Rev 1/2001 11595

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Daniel M. Derrick 201^{Year} 20:44 January Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Bethesda Suburban Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Month, Day, Year) Oct. 5 1917 1 M M 2 - F Months Hours Min 572-18-6732 94 Oct. Maryland Yrs. Director Usual Residence of Decedent should be filed within 72 row...
and Mental Hygiene.
7 is marked other than "natural", or items 23a or 28a-f show
in event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Gaithersburg Montgomery 1 Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20877 403 Russell Avenue, Apt. G-1 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☒ No Specify: White Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Patent Law U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mosteller Margaret traumatic Bruce Berger Derrick permit. Page 1 and 2 should be Department of Health and Mer Important: If item 27 is marks any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20832 Christine Hill Wilson/Per.Rep. 17801 Georgia Avenue, Olney, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 🗹 Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 1/6/2012 Alexandria, Virginia Metropolitan Crem. 21. Signature of Funeral Service License 22. Name and Address of Facility Muriel H. Barber Funeral Home P.O. Box 5038, Laytonsville, Maryland 20882 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Atherosclerotic Cardiovascular Disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami burial-transi that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical Box 68760 the as use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown for Month Day Year Pregnant at time of death be detached 9 Unknown signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed pinous peen 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a Was an page 2 s autopsy performed? Yes 2 within 24 hours after death. To the Funeral Director: After this certificate has Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗹 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Division of 27. Manner of Death 28b. Time of 28c. Injury at work? 1 🔲 Yes 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 2 🗌 No Accident Investigation upleted filled in by the 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 31027 January 3, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ら 20814 Paul D. O'Brien, M.D. 8600 Old Georgetown Rd., Bethesda, MD

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

JAN 0

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #26 per MD FCHD TM 1/9/12 State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2^{Day} 2012^{Year} Physician/ 11:55 P M January Donald DeWitt Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Garrett Garrett County Memorial Hospital 0akland 8. Date of Birth (Month, Day, Yea Oct. 18, 1 9. Birthplace (State or Foreign Country) Maryland . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Number **Funeral** Days Hours Min. Months 1 XM 2 □ F 72 Ĩ939 Director 215-36-9098 Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at should be filed within 72 hours after death with the Maryland and Mental Hygiene.
is marked other than "natural", or items 23a or 28a-f shov aumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 No 0akland Maryland Garrett 10f. Zip Code 10e, Street and Number 10a. Citizen of What Country? USA Funeral 21550 177 Waterwheel Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2 XNo If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Dairy Salesman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 27 is marked or traumatic eve Daisy Friend 2 Richard DeWitt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Erma DeWitt / Wife 177 Waterwheel Rd., Oakland, MD 21550 and 2 s Health a other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1. Department of I Important: If ite any injury or of ō 1 X Burial 2 Cremation 3 Removal from State Frederick, Maryland 1/9/2012 4 Donation 5 Other (Specify) Zion Cemetery Stauffer Funeral Home 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Immediate Cause (Final Davamous Physician/ disease or condition Medical resulting in death) (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): attending physician and for use as the burial-transit that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Day Year Yes 2 No 1 Yes 2 9 Unknown detached 9 Unknown P.O. s been signed by should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Nnknown Records, 24b. Were autopsy findings available prior to completion of cause of death? has autopsy page 2 performe 2 L Yes of Vital within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home esidence 6 - Other (Specify) 2 No ၉ 1 Inpatient 2 X ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: (Month, Day, Year) 5 Pending Division 1 Yes 2 No M Accident Investigation Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death account at the cause(s) and manner as stated. Medical 29a. Certifier Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practions: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certif 29c. License number P 1.3.12 D-23979 Coralski, MD 311 North 4th St., Oakland, MD 21550 30. Name and add O Robert 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend 26, per phy, 9923 1-23-12 sm State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ off 13/2012 7:26 PM Marion Carole Dunn Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Westminster Carroll Hospice Dove House If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number **Funeral** Days Country Director 58 212-50-3680 1 M 2X F 12/15/1953 MD Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location with the Maryland notified at Director 1 Yes 2 No MD Carroll Upperco 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò th and Mental Hygiene. 27 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be. Funeral 21155 3828 Carrollton Road death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Armed Forces? 1 ☐ Yes 2 X No Black, White, etc. 1 Never Married 2 Married þ within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Cover Girl Cosmetics 12 Brand Coordinator permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, the Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Charles Glos Nancy Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) James Dunn/husband 3828 Carrollton Road, Upperco, MD 21155 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) Carroll Cremation 01/18/2012 | Hampstead, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Addre Princes Funeral Home and Chapel, 412 Washington Road, Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician. אלמח disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner RUMONIZA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) by the attending physician tached for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. יסי, איני דווא certificate has been signed I the funeral director, page 2 should be det Be Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 No □ Nursing Home 5 □ Residence 6 🕱 Other (Specify) Hospice မ 1 🗌 Yes ER/Outpatient 3 DOA Date of injury (Month, Day, Year) 28b. Time of Manne of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending s after death. Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined within 24 hours at To the Funeral D completely filled i the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 100039943 1612012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 357 Mel Mo 32. Registrar Signat State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Ertlmeier JEDIC Physician/ Month Year 532 PM 20 V Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Mandrin Inpatient Care Center Harwood If Under 24 Hrs Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) **Funeral** Director 103-22-5888 1 **X** M 2 □ F New York b8/18/1930 81 Usual Residence of Deced 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f s er must be notified Annapolis Maryland Anne Arundel 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 7308 River Crescent Drive 21401 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or iter Armed Forces?

X Yes 2 No Black, White, etc. by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. Retired 1 ☐ Yes 2 X No Specify: Completed Specify: 3 Widowed 4 Divorced White er than "natur , the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene is marked other the raumatic event, the 5+ United States Marine Corps Pilot Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce. Frieda DeMario Joseph Ertlmeier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Margaret Ertlmeier/ Wife 7308 River Crescent Drive, Annapolis, MD 21401 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗆 Burial 2 🗶 Cremation 3 🗆 Removal from State crematory or other place) Kalas Crematory 4 ☐ Donation 5 ☐ Other (Specify) 01/04/2012 Edgewater, Maryland f Funeral Service Licens Signatu 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, MD 21037 at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, i each line. 23a. Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause of Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last the burial-tran attending physician and Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director Advances. use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the funeral director, page 2 autopsy perform ☐ Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No ပ NOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🗷 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after death Funeral Director: Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 00 64370 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Perkum miscol

State Registrar JAN 05

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Villard J. Ellis	State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. 2012 0166
Physician/	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year
Medical Examiner	W111ard James E111s January 12, 2012 1850 nrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
	Dorchester General Hospital Cambridge Dorchester
Funeral Director	5. Social Security Number 213-40-9328 1 X M 2 F 69 Yrs. 70 Yr
	Usual Residence of Decedent
w aoy	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No
Maryland 28a-f show d at occe. rector	MD Talbot Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
with the Maryland us 23s or 28s-f sho be notified at occe.	
0036 within 72 hours after death with the Maryland giene. her than "natural", or items 23a or 23a-f she Medical Examiner, must be notified at noce ompleted by Funeral Director	11. Marital Status 1 Never Married 12. Was Decedent Ever in U.S. 1 Never Married 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian, Black, White, etc.
s after or rail", or ainer in	3 Widowed 4 Divorced of Pates: 1 Yes 2 No specify: Specify: White
hours fastur Exam	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
5-0036 ed within 72 hour ed within 72 hour other than "natu the Medical Exaut Completed	2 Technical Engineer Telecommunications
1215-0036 Id be filed within 72 hours after fental Hygiene. sarked other than "natural", event, the Medical Examiner Dee Completed by 19	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Foster A. Ellis Mildred King
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than ic eveot, the Media	Foster A. Ellis Mildred King 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MD d 2 shou lth and lt	Frances Sharon Ellis/Wife 224 South Aurora Street, Easton, MD 21601
re, re land f Healt f fitem er tran	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 1 Surial 2 Cremation 3 Removal from State crematory or other place) 20c. Location - City or Town, State
Baltimore, pernit. Pages la Department of He Important: If ite	4 Donation 5 Other Specify: Fort Lincoln Cemetery 2012 Brentwood, MD
Baltimore, MD 2's permit. Pages I and 2 should Department of Health and Mc Important: If item 27 is mainjury or other traumatic e	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W, Silver Spring, MD 20901
Physician	23a. Part Enter the disease, or complications that causes the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and
/Medical Examiner	Immediate Cause (Final disease a. Hypertensive atherosclerotic Cardiovascular Disease Death
	b b
iner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause
0, be executed sician and sician and burial - transit edical Examiner	(Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):
60, the be executed by sician and burial - transit	d. ☐ AMENDED 23a, pt.II,27 per me g924 2-2-12 vt
8760 tificate Ing phys	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 21c. If yes, outcome of pregnancy 23d. Date of delivery 23d. Date of delivery 24d. Date of delivery 25d. Date of delivery
b. Box 6876(the death certificate the attending phy oby the attending phy ched for use as the the Physician/Mk	1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown
P.O. Be that the de ned by the detached if by Phy	
Records, P.O. The law requires that the ficate has been signed by, page 2 should be detack. Completed by F.	Chronic Renal Disease, Diabetes Mellitus
cords, law requi has been 2 should	24a. Was an autopsy findings available autopsy findings available prior to completion of cause of
Reco	performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
Vital Rec ysician: The l his certificate l director, page	25. Was case referred to medical examiner? Hospital: 4 Positions 2 FR/Outpotient 3 POSA Others Nursing Home 5 Residence 6 Others
ing Physi After this funeral dii	1 V Yes 2 No 280 Date of Injury
sion (trendin death. ctor: A y the fun	1 X Natural 5 Pending 2 Accident Investigation
Division of Vital Records, spital or Attending Physician: The law require nours after death. oeral Director: After this certificate has been si filled in by the funeral director, page 2 should be Certification: To Be Completed	3 Suicide 6 Could not be determined determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State)
達 点 音 	
	and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
2-PEND	(Caclaheur) O.C.M.E. January 14, 2012
	30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223
State	31. Date filed (Month, Day, Year) 33. Registrar's Signar re
Registra	JAN 18 2012 Jenus B. Aller

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien) 1 - For State Ragistrar Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 4:45 A Natalie Joyce Easterday January 9, 2012 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Coffman Nursing Home Hagerstown Washington If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 1 □ M 2 🛚 F Days Hours Min Yrs. 217-30-6176 May 10, 1934 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Maryland Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1304 Pennsylvania Avenue 21742 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 State of Maryland Personnel Director 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Deloss Andrew Barnhart The 1ma Stottlemyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda K. Cole/daughter 17530 Stone Valley Drive Hagerstown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Lena Cemetery 01-12-2012 Boonsboro, Maryland 21. Signature of Funeral Service 22. Name and Address of Facility Bast-Stauffer Funeral Home, PA 7606 Old National Pike Boonsboro, MD 23a. Part1. Phter the disease, or complicate shock or heart failure. List only one Approximate Interval Between Onset and Death Mat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, a on each line. Immediate Cause (Final disease or condition resulting in death) PEREBROVASCULAR teed oni 2-3 DAYS Due to (or as a consequence of): DISAME CORMEMNY myong Y EMMY Due to (or as a consequence of) DEBLUTY 4 Emrs Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 34No 1 Yes 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 Yes 2 No

Physician /Medical Examiner Examiner burial-transit

that the death certificate be exec

the attending physicien

certificate has

After

within 24 hours after death.

To the Funeral Director: A

Hospitel or Attending

funeral dir

filled in by

the

Physician/Medical

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Completed

Be

2

Certification:

Medical

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Director

Funeral

ģ

Funeral

Director

If item 27 is marked other then "natural", or items 23a or 28a-f show or other treumatic event, the Medical Examinat must be notified at

a filed within 72 hours after at Hygiene.

other then "natural", or fter

Pages 1 and 2 should be fill ment of Heelth and Mental H ant: If item 27 is marked out

permit. Page Department of Important: If any injury or

Baltimore, Maryland 21215-0036

the Manyland

death with

if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant

Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner?

2 ER/Outpatient 3 DOA

Other: Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

27. Manner of Death 1 Natural 2 Accident

28a. Date of Injury (Month, Day Year) 5 Pending investigation 6 Could not be determined

28c. Injury at Work? 28b. Time of Injury 1 ☐ Yes 2 ☐ No

29a. Certifier (Check only one)

3 Suicide

4 Homicide

1 🕇 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MI HETWA THEBYNUND

28f. Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar

1190 GIMMAND 31. Date filed (Mo.

Registrar's Signatu

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JANUARY 6,2012 Year TABLER ESWORTHY 6:40P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 9. Birthplace (State or Foreign **Funeral** Age (In vrs. last birthday) 8. Date of Birth Hours Min June 26, 1 □ M 2 🟋 F 73 1938 Maryland 219-34-8823 Director Usual Residence of Decedent ıral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7046 Catalpa Road 21703 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 N No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc "natural", or 1 Never Married 2 X Married þ 1 ☐ Yes 2 X No Specify Specify: White 3 🗌 Widowed 4 🗎 Divorced Completed Year or Dates event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. fant: If item 27 is marked other than 'ury or other traumatic event, the Me jury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) U.S. Government 12 Administrative Officier Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ဂ James Milton Tabler Florida Washington Sheckles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles T. Esworthy - Husband 7046 Catalpa Road, Frederick, Maryland 21703 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Metropolitan Crematorium 1/8/2012 Alexandria, Virginia 21. Signature of Funeral Service Licensee Molesworth-Williams P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate
Interval Between
Onset and Death
2 years shock, or heart failure. List only one cause on each line Immediate Cause (Final Metastatic nonsmall cell lung cancer years disease or condition resulting in death) Due to (or as a consequence of) Pneumonia 1 month Sequentially list conditions Due to for de diconeccuance of, fraily, leading to immediate cause. Enter Underlying Examin Cause (Disease or iinjury that initiated events resulting in death) Last COPD 10 years Due to (or as a consequence of): Physician/Medical IF FEMALE

Physicians/) Medical Examiner

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

-transit and burial-

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Completed

Be

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Certificate:

Medical

29a. Certifier

(Check

only one)

23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? G.I. Bleeding 1 Dres 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 INO 1 Tes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending iniury Accident
Suicide Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number,

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

attending physician for use as the buria Physician: The law requires that the death certificate be Box 68760 P.O. signed by t Division of Vital Records, 2 should certificate has page funeral director, After this Hospital or Attending within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu

(5)

Registrar

31. Date filed (Month, Day, Year) State

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month. Day, Year

City or Town, State,

Name and address of person who completed cause of death (Item 23a) (Type, Print)

determined

W

32. Redistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Evans 2:06 thew 10 2012 Januar /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Princess Somerset 11983 Drex wood Drive If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 1 2 M 2 □ F Maryland 118-34-3372 June, 15 1940 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, ite Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State Hnne Prince \$5 1 Yes 2 □ No Somerset Director Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21853 11983 Drex wood U.S. A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 25 No If Yes, Give/ Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black þ 3 ☐ Widowed 4 ☑ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Contractor Renovation private Home 10th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Evans Matthew J tva Wright ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Salisbury, MD, St Brand: Evans-Lake daughter 606 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Bunal 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Chance Charles U.M. C. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Anthony E. Ward 30639 Ave Princess Anne, MD, 21853 Hampden 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. AS CVD Approximate Interval Between Onset and Death years Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner physician and s the buriat-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23h Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 □Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify). ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Tyes 2 No 3 Probably 4 Vunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 2□No 20 1 ☐ Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 les 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □Other (Specify) မ 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident neral Director: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide determined 4 Homicide To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State

Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OGOYOV
32. Registrar's Signature

D006 9816

1665 Woodbrooke

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 15,2012 JAN -ROLLANDE ESTHER EBACH 8:56A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 135 STODDERT AVENUE CHARLES WALDORF If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 005-26-3284 Director 1 🗆 M 2 🔀 F 12-13-1930 81 N.Y. Yrs. Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10d Inside City Limits Director MD. CHARLES WALDORF 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò or than "natural", or items 23a or the Medical Examiner must be Funeral 135 STODDERT AVENUE 20602 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 XNo Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Specify: WHITE 3 ₩ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life DO NOT use retired Elementary/Secondary (0-12) College (1-4 or 5+) MD. BANK & TRUST BANK TELLER should be filed with and Mental Hygien. 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည ROLAND HENRY CAYER EVELYN A. OUELLETTE other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PAUL EBACH-SON 26474 LAUREL GROVE CT. MECHANICSVILLE, MD. If item 27 20a. Method of Disposition 20c. Location - City or Town, Sta2065920b. Place of Disposition (Name of Burial 2 Cremation 3 Removal from State ţ injury or MD. VETERANS CEM. Department Important: If any injury or CHELTENHAM, MD. 1-20-12 Donation 5 Other (Specify) 23a. Part 1. Enter the disease, or complifedions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

Immediate Cause (Final Approximate Interval Between Onset and Death HENST DISEASE Immediate Cause (Final Physician/ HYPERTEN SIVE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Ity I'M TIENSINN Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of that initiated events resulting in death) Last Due to (or as a consequence of): ng physician a as the burial-Physician/Medical death certificate be Box 68760 use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 month 1 Yes 2 No ρģ Month Day Year the Unknown g Unknown Hospital or Attending Physician: The law requires that the P.O. ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DIMENES MELITUS Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Hypezzin Dem A 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed Yes 2 No 1 🗌 Yes 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred eral Director: After if filled in by the funer 1 🗗 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral Completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b, Signature ar

State

DHMH 17 Rev 06-2011

Registrar

son who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Smith no

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 01/02/2012 ADOLPHE JOSEPH FRENCHE 0837 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Suburban Hospital Bethesda Montgomery If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Min. Hours 215-72-7092 Director 1 🖾 M 2 🗆 F 91 03/24/1920 Trinadad show ral", or items 23a or 28a-f sho Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 XYes 2 No Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2 Village Green Court 20876 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14 Race - American Indian Black, White, etc. 1 Never Married 2 XMarried þ Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: Black 3 Widowed 4 Divorced Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Trinada & Tobago Elementary/Secondary (0-12) College (1-4 or 5+) yrs Regimental Sqt. Major Regiment Force is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk ည Joseph Frenche 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Nora Frenche/wife Village Green Court, Germantown, MD 20876 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2 XCremation 3 Removal from State 4 Donation 5 Other (Specify) Ardent Cremation Svc | 01/09/2012 | Hanover, MD 21. Signature Funeral Service Lice 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final Onset and Death Physician/ Cardiac arrest disease or condition Medical resulting in death) **Examiner** Coronary artery disease Sequentially list conditions, if any, leading to immediate cause. Enter underlying Due to (or as a consequence of) Exami Cause (Disease or injury that initiated events resulting in death) Last Ischemic cardiomyopathy and Due to (or as a consequence of): Physician/Medical Cerebrovascular accident 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Seizure disorder Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed HTN Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? Chronic renal failure 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 X No 1 Inpatient 2 X ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 XNatural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined

To the Hospital or Attending Physician: of the state of th within 24 hou **To the Fune** completely fi

> 3200 Tower Oaks Blvd., #110, Rockville, MD 20852 Ajay Reddy, MD 31. Date filed (Month, Day, Year) State JAN 06 201

32. Registrar's Signature

empleted cause of death (Item 23a) (Type, Print)

Registrar

Medical

29a. Certifier

(Check

29b. Signature and title of cert/fie

30. Name and address of person who c

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

01/02/2012

29c, License number

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Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	To the Euneral Director Affer this certificate has been signed by the ottending whysician and

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Physicia Medic Examin	al	Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) William Harold Frampton 4a. Facility Name (if not institution, give street and number) Leading The Certificate of Death Ab. City, Town, or Location of Death Leading The Certificate of Death Ab. City, Town, or Location of Death Leading The Certificate of Death Lead
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s after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at	Funeral	18410 Point Lookout Road 20667 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
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2 should be tth and Men 27 is marke traumatic		William Frampton Olive Stifler 19a. Informant's Name/Relationship (Type, Print) Michael L. Wasilow/Nephew 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18410 Point Lookout Rd.Park Hall, MD20667
t. Page tment o tant: If ijury or		20a. Method of Disposition Date Chesapeake Crem. 1/9/2012
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dung, such a pardiac or respiratory arrest, Approximate Intervel Returners
Pnysician/ Medical Examiner	er.	disease or condition resulting In death) Due to (or as a constituence of): ARDS Sequentially list conditions,
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60×1/2		29b. Signature and title of Certifier 29c. License number 29d. Date signed (Month, Day, Year) 01-06-9012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Stat Registra	e ir	ABBAS A. OMAIS, M.D., CENNA MEDICAL CENTER, 1-C POST OFFICE RD, WALDORF, MD 20602 31. Date filed (Month, Pay, Year) 0 2012 32. Posistrar's Signature. D. Janes

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Campbell Finley 2012 Elliott 9:51 P.M January Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 6550 Christmas Tree Lane Huntingtown Calvert Social Security Numbe **Funeral** 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Months 1 X M 2 🗆 F 1070371927 224-30-5241 Director 84 Washington, Usual Residence of Decedent or 28a-f show e notified at 10b. County 10a. State 10c. City, Town or Location and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director MD 1 ☐ Yes 2 🕅 No Calvert Huntingtown 9 10e. Street and Number 10f. Zip Code ms 23a or must be r 10g. Citizen of What Country? Funeral 6550 Christmas Tree Lane 20639 U.S.A. rral", or items ? I Examiner mus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black White etc Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", 3 Divorced Year or Dates 1946-47 Specify. white the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. Fitem 27 is marked other than other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Library of Congress administrator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Elmer George Finley Hulda Johanna Pletzer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virgie D. Finley, spouse 6550 Christmas Tree Lane, Huntingtown, MD 20639 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 Department of H Important: If ite any injury or ot 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 01/03/2012 Alexandria, VA Signature of Funeral Service Licenses 22. Name and Address of Facility Rausch Funeral Home, MOO715 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Inset and Death Physician/ disease or condition resulting in death) ,ea Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate Due to (or as a consequence of): Cause (Disease or iinjury attending physician and for use as the burial-transi The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No ☐ Pregnant at time of death☐ Unknown ate has been signed by the a page 2 should be detached to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Yes 2 No 3 Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Director: After this certificate 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to me filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner eath 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury Hatural work? 1 □ Yes 2 □ No death Investigation Accident M 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined after 24 hours a Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. npleted (Check Medical Examiner: O s of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 only one Certifying Nurse Practione o the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and th Name and address erson who completed cause of death (Item

DHMH 17 Rev 7/2009

State Registrar

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Medica Examine		Doug1 4a. Facility Name (if	not institution, g	ive street and number		10 Sec	4b. City, Town, or	Location of	Death		40	c. County of I	Death .	
Funeral		5. Social Security No	*/			ast birthday)	If Under 1 Year Months Days	If Under 2	4 Hrs. Min.	8. Date of Bir (Month, Da	th	9.	Birthplace (State or Fore	ign
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Page 1 an nent of He int: If iterr iry or othe				Removal from Sta	te C	emetery, crer	osition (Name of matory or other place Cemetery	1		Date /2012		ocation - Cit	y or Town, State	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Betty Louise Feeser January 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Meritus Medical Center Hagerstown Washington County If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Hours 205-16-7319 **Director** 85 1 □ M 2 🗶 F 23, 1926 Pennsylvania Usual Residence of Decede 28a-f show äţ 10a. State 10b. County 10c. City, Town or Location Director traumatic event, the Medical Examiner must be notified Maryland Washington Co. Hagerstown 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 832 Pine Street USA 21740 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces Black, White, etc. 9 Completed by 1 Never Married 2 Married 1 Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: "natural", 3 Widowed 4 □ Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) 12 College (1-4 or 5+) Engineering Office <u>Secretary</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Cyril T. Sheely Grace E. Dodrer permit, Page 1 and 2 should Department of Health and Me Important: If Item 27 is mar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phillip E. Feeser / Son 832 Pine Street, Hagerstown, Maryland injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 X Removal from State cemetery, crematory or other place Evans Cremation Svc. Jan 12,2012 Leola, Pennsylvania 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Douglas A. Fiery Funeral Home any Eastern Blvd. N., Hagerstown, MD 21742 3a. Part 1. Enter th, disease, or complications that cause of edeath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heavy ailure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Due to (or as a consequence of Physician/ Medical Due to (or as a c Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) inding physician and use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No for Month detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown P.O. þ Part <mark>II. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ been signe should be o Records, Completed 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? has page 2 autopsy perform Yes 2 No Division of Vital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tes Other: 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) s after death. 28b. Time of 28c. Injury at 28d. Describe how injury occurred Naturai 2 Accident 3 Suicide Homicide 5 Pending work?
1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by To the Hospital within 24 hours a To the Funeral D Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 29b. Signature and title of certifier of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address Boonsburo MD 21713 20311 Lappans Rd Malk MD

5:00 AM

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

week

Year

White

Y☐ Yes 2 ☐ No

DHMH 17 Rev 06-2011

State Registrar Date filed (Month.)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DAVID RAY FITZROY JANUARY 2012 13:15 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UNION HOSPITAL OF CECIL COUNTY ELKTON CECIL 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. (Month, Day, Year JLY 25 1 Director 212-94-6990 52 PENNŚYLVANIA Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at lid be filed within 72 hours after death with the Maryland Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🕅 No CECIL MARYLAND ELKTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 934 WEST PULASKI HIGHWAY 21921 UNITED STATES Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2XXNo Black, White, etc. Completed by 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes. Give 1 ☐ Yes 2XXNo Specify: WHITE "natural", 3 Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 CUSTOMER SERVICE RESTAURANT marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ GEORGE FREDERICK FITZROY injury or other traumatic ROSA LEE BUTLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Page 1 and 2 sl ment of Health a tant; If item 27 i 934 WEST PULASKI HIGHWAY, ELKTON, MARYLAND <u> VICKI L. HOLBROOK / SISTER</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important; If ite
any injury or ot JANUARY cametery, crematory or other place)
NORTH EAST UNITED
METHODIST CEMETERY 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation fo ☐ Other (Specify) 10, 2012 NORTH EAST, MARYLAND 21. Signature Fy 22. Name and Address of Facilita CROUCH FUNERAL HOME, P.A. SOUTH MAIN STREET. NORTH EAST, MARYLAND 21901 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the diseas Approximate Interval Between Onset and Death shock, or heart failure. st only one cause on each line Immediate Cause (Final Physician/ reumoma disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Other (specify) 1 Yes 2 9 Unknown 4 ☐ Pregnant : 9 ☐ Unknown the b signed b Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed is certificate has been si director, page 2 should 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death?

1 Yes 2 No autopsy perform Director: After this certificate | Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Hospital: Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 X Natural iniury 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0062190 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAHNAWAZ KHAN UGUSTINE HERMAN HWY SUITE A, CHESAPEAKE CITY State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First Middle 1 ast) Physician/ Louise Ann Forsyth Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Rockville Shady Grove Adventist Hospital If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number **Funeral** Days Hours Min 96 094-01-8588 Director 1 🗆 M 2 🔀 F 2 show 10a. State 10c. City, Town or Location ms 23a or 28a-f sho must be notified at death with the Maryland Completed by Funeral Director MD Montgomery Village Montgomery JANUARY 10e. Street and Number 10f. Zip Code 20886 19440 Brassie Place ral", or items? 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: "natural", 3 X Widowed 4 ☐ Divorced Year or Dates Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Office Manager LOU15 Be 17. Father's Name (First, Middle, Last) မ De Stefan Elsie 19a. Informant's Name/Relationship (Type, Print) FORSYTH, John Forsyth / Son 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Parklawn Memorial Park Name and Address of Faci M00956 Immediate Cause (Final Physician, neumonia disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** atrial fibrillation Sequentially list conditions, if any, source of the Underlying Cause (Disease or injury that initiated events sician and te burial-transit trakture hip Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death, Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic prog 5 Other (specif in the past 12 months?

1 Yes 2 No been signed by the atter should be detached for Pregnant at time of death 9 Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice completely filled in by the funeral director, 25. Was case referred to medical Be examiner? Hospital Other: 2 No ᅆ 1 Tinpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 🔀 No 12/27/2011 unknownM Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined home 29a. Certifier only one 29c, License number D0064413

2. Date of Death 2012 January 9:20 a M 4c. County of Death Montgomery 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) April 7, 1915 10d. Inside City Limits 1 🗌 Yes 2 🔀 No 10g. Citizen of What Country? United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Specify: Caucasian 16b. Kind of Business/Industry Retail 18. Mother's Name (First, Middle, Maiden Surname) Puer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19440 Brassie Place, Montgomery Village, MD 20886 20c. Location - City or Town, State 01/09/2012 Rockville, MD 22. Name and Address of Facility
Thibadeau Mortuary Service, p.a. 7 Park Avenue, Gaithersburg, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mt 1 23d. Date of delivery 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform 2 N 1 Yes 2 No Yes 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred transter +0 bed 28f. Location (Street and Number or Rural Route Number, City or Town, State) 19440 Brassie Place montgomeny village, MD Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Gertifying Nurse Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) January 2, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Pri 9901 Medical Center Drive, Foukville, Maryland 20850 Juanita Smith, 31. Date filed (Month, Day, Year Registrar's Signat re JAN 1 0 2012

State

Registrar

Physician/ January 6, 2012 Fortunato Erlinda Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Ft. Washington Hospital Ft. Washington 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Months Days Hours **Director** NONE 60 1 M 2 X F 10/20/1951 or 28a-f show permit. Page 1 and 2 should be filed within remove when the latest and 28 should be partment of Health and Mental Hygene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examiner must be notified at 10b. Count 10c. City, Town or Location Director Maryland Prince George's Oxon Hill 10e. Street and Number 10f. Zip Code Funeral 6804 Leyte Drive 20745 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Completed by 1 Never Married 2XXMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: If Yes. Give 3 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 years Housekeeping 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Melquiades Rivero Conception 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Emile Fortunato / Daughter Leyte Drive Oxon Hill, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) TXX Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 01/14/2012 Resurrection Cem. 22. Name and Address of Facility George P. Kalas Funeral Home PA 21. Signature of Funeral Service Licensee 6160 Oxon Hill Rd. Oxon Hill, Maryland Part 1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on each ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Arteris sclentic Heart Disence Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Por Pregnant at time of death 5 Other (specify) 1 Yes X2 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an page 2 Hospital or Attending Physician: Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျ 1 Inpatient 2xxx 5xVOutpatient 3 IDOA filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 1 KNatural 5 Pending
Investigation work?
1 Yes 2 No Accident 2 Accident
3 Suicide
4 Homicide within 24 hours after deatl To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 35206 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Livingstu Road

TANNER

Mn

1. Decedent's Name (First, Middle, Last)

DHMH 17 Rev 06-2011

Registrar

11701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Death

4c. County of Death

10g. Citizen of What Country?

Philippines

16b. Kind of Business/Industry

Avache

Domestic

20c. Location - City or Town, State

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

Month

autopsy

Clinton, Maryland

20745

Interval Between Onset and Death

14. Race - American Indian Black, White, etc.

Specify: Filipino

Prince George's

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 Yes 2XXNo

Philippines

10:50 Pm

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 2012 Month GAMISON 10:10 PM SADIE P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WICOMICO 1723 TWIN ALISISORI MANE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Min 218-16-9313 Director 1 D M 2 KF MD 1-13-1924 8. 28a-f show 10a. State ms 23a or 28a-f sho must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 Yes 2 No MD SALISBURY WICOMICO 10e, Street and Numb 10f. Zip Code 10g. Citizen of What Country? 1723 TWIN LANE 21801 USA items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, item 27 is marked other than "natural", or iter other traumatic event, the Medical Examiner Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 KNo Specify. Specify: BLACK 3 Nidowed 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. Once, SARA ELLEN JONES JOHN ULA BARCLAY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CYNTHA JOHNSON (daughter 20a. Method of Disposition 1723 TWIN LANE SALISBURY, MD 21801 20c. Location - City or Town, State 20b. Place of Disposition (Name of Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 1-14-12 4 ☐ Donation 5 ☐ Other (Specify) NANTICOKE, MD NANTICOKE CEMETERY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MESSICK FUNETAL HOME POBOXGI BIVALLYE MOD 21814 Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 110 hu disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence oi). attending physician and I for use as the burial-transit Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month Dav Year been signed by the a 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 4 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 24 hours after death.

Funeral Director, After this certificate has page 2 Yes 2 No 1 Yes 2 Pro 25. Was case referred to medical Hospital or Attending Physician: funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) ၉ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work?
1 Yes 2 No Accident Investigation the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, filled in by determined City or Town, State) Medical 29a. Certifier 1 🗜 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 | | within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 20/1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HUGAM WAST 0 31. Date filed (Month, Day, Year) 32. Raistrar's Signature State JAN O

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 26 per 1/25/12 dk
State of Maryland Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JAN.14 Day 2012 Physician/ DOROTHY MARIAN GASKI 5:15AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2915 MILL HILL ROAD WALDORF CHARLES If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Months 3-22-1916 307-01-5082 **Director** 1 □ M 2**X** F 95 28a-f show 0a. State 10c. City, Town or Location 10d. Inside City Limits at 10b. County Director notified 1 Yes X No IN. LAKE CROWN POINT 10e. Street and Numbe 10f. Zip Code ō 10g. Citizen of What Country? ral", or items 23a or Examiner must be 765 WEST ELIZABETH DRIVE 46307 U.S.A. 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ò 1 Never Married 2 Married Maryland 21215-0036 an "natural", Medical Exar 1 Yes 2 No Specify. 3

✓ Widowed 4 □ Divorced Specify:WHITE Completed 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) LAKE CO.CONVALESCET and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the NURSING HOME ADMINISTRATOR HOME 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ JULIUS DENNIS MACEDO SARAH EUDORA JACKSON permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 765 WEST ELIZABETH DR. CROWN POINT, IN. 46307 JULIE GASKI-DAUGHTER Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗆 Burial 🗶 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) METROPOLITAN CREMATORY 1-17-12 22. Name and Address of Faci MQ0479 RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do n shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (of the a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) ding physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day 5 Other (specify) Month Year signed by the at d be detached for 1 Yes 2 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate 2 📈 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Hesidence 6X Other (Spe daughter' residence S ျှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day Division of 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1XNatural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature a 20/2 completed cause of death (Item 23a) (Type, Print) Belle HAVENRO, ALEXANDRIA VA 22307 Sylvia A LARKIN MD

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January Ý2012 8:10 PM Jean Theresa Gasparovic Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Calvert Prince Frederick 420 West Dares Beach Road Apt. 111 If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Days Min 1 M 2 F 05/106/11941 Michigan 376-42-1245 70 **Director** Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Maryland Calvert Prince Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 420 West Dares Beach Road Apt. 111 20678 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 'natural", or Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🎇 No Specify: White 3 XXWidowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Mex Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Margaret Hursky Raoul Belanger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 134 Stratford Ct., New Stanton, PA 15672 Michael A. Gasparovic / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 01/14/2012 Hillcrest Memorial Owosso, Michigan 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rausch Funeral Home, PA. 4405 Broomes Island Road, Port Republic, MD 20676 21, Signature of Funeral Service Licensee Kyle S. Simons M01206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final lore tron acute myo cordial Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** opr ten Sion Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury melly tus diobetes Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death Yes 2 No 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed Yes 2 No 1 🗌 Yes 2 🗌 No 26. Place of Death (Check only one) **Division of Vital** Be 25. Was case referred to medical examiner? Other: 4 \square Nursing Home 5 X Residence 6 \square Other (Specify 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ည 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 27. Manner of Death 28d. Describe how injury occurred Certificate: 5 \square Pending ₩ Natural 1 ☐ Yes 2 ☐ No 2 Acciden Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, within 24 hours aff

To the Funeral Di

completed filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MAndono D0060638 1/9/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20678 ROAD # 310 PRINCE FREDERICH 110. HUSPITAL ID

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

32. Registra & Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

Kermit L. Guss	_	- For State	ate of Ma	ryland / I		tment of			d Ment	al Hy	/giene	Der N	20	112	0168
Physician Medical Examine	7	t egistrar 1. Decedent's Name (First, Middle Kermit Lee		ss							2. Date of D Month January	Reg. No Death Day		I	3. Time of Death 1617 hrs
		4a. Facility Name (if not institution	•	Town, or e Fred	Location of erick	f Death	banaarj	1, 20	tc. County of Calvert	Death					
Funeral Director		5. Social Security Number 248-76-1185	6. Sex		-	t birthday) Yrs.	If Und	er 1 Yea			-				nplace (State or Washington
any		Usual Residence of Decedent Toa. State 10b. County	M223-101 Z		Dc. City, To	own or Location			<u> </u>	<u> </u>					10d. Inside City Limits
<u>}</u> .		Maryland Prin Oe. Street and Number	ce Geoi	rge's	Up	per Mar	10f. Zip					10g. C	itizen of Wha	it Coun	1 Yes 2 XX No
with the Maryland ms 23s nr 28s-f sho be notified at once paral Director		9215 Columb		ne s Decedent Ev	ver in U.S.					in? (Sp	ecify Yes or	No-		SA Americ	an Indian, Black,
Baltimore, MD 21215-0036 Departine Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiers than "natural", or items 23a nr 28a-f she injury or nither traumatic event, the Medical Examiner must be notified at once To Re Completed by Finneral Director		1 Never Married 2 Ma 3 Widowed 4 N Divo	orced If Yes, Gir	ve Year 1962	No .–196	7 1	Yes 2	□X No	specify:		Rican, etc.)	lia	White,	Wh	ite
5-0036 ed within 72 hour lygiene. inher than "astu the Medical Exan	paadu	15. Decedent's Education (Spec Elementary/Secondary (0-12) 10		ege (1-4 or 5+)		6a. Decedent during mo Self	st of wor	king life	tion (Give k . DO NOT L	and of w	red)	Ĩ	Kind of Bus		dustry
1215-0036 I be filed within 7 ental Hygiene. vent, the Medical Re Comple		7. Father's Name (First, Middle, Donald De	e Guss							E	11a M	ae H			
MD 21 2 should th and Me 27 is man mastic cv	2	9a. Informant's Name/Relationsh Sandra Sue Wa1		•		19b. Mailing 2392							City or Town f , $$ $$ $$ $$ $$ $$ $$ $$ $$		Zip Code) 602
Baltimore, I permit. Pages I and Department of Heal Important: If item injury or other tra		20a. Method of Disposition 1 XX Burial 2 Cremation 4 Donation 5 Other Sp		oval from State	Mar	ace of Disposite matery or other yland Cemeter	vere			Jan 20	Date 17, 012		Location - 0 he1ter	-	•
Balti permit. Departm Imports	2	21. Signature of Funeral Service Aплана М Erg1	insee	(5)		22. Na 82	ame and 00 J	enn	ifer l	Lane	e, Owi	ngs,	MD 20)736	vert, P.A.
Physician /Medical Examiner		23a. Par (I. Enter the disease, or failure. List only one cause mmediate Cause (Final disease	on each line. a. Atheros	sclerotic Ca	ardiovas			of dying,	such as ca	ardiac or	respiratory	arrest, sl	nock, or hear	t	Approximate Interval Between Onset and Death
		or condition resulting in death) Sequentially list conditions, f any, leading to immediate	b	r as a consequ											
cuted and transit	Tyalling	ranse, leading to infinediate cause. Enter Underlying Cause Disease or injury that initiated events resulting in death) Last	c. Due to (o	r as a consequ											
execui an and al - tra		UNPENDED	d. AMENI	DED								·			
Division of Vital Records, P.O. Box 68760, within 24 hours after death certificate be within 24 hours after death. To the Runeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buring edical Certification: To Be Completed by Physician/Medical Certification:		F FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unk	1 1 4	yes, outcome Live birth Pregnant at tim Unknown		2 Feta	al death er (Spec	3 [cify) _	Ectopic	pregnai	ncy	2	3d. Date of d Month	lelivery Di	ay Year
s, P.O. I irres that the signed by the detached by Physical Br. Physic	2	Part II. Other significant conditi	ons contribu	ting to death b	ut not resu	ulting in the ur	derlying	cause g	jiven in Par	t I.				_	ne cause of death?
Division of Vital Records, P.O. tal mattending Physician: The law requires that the start death. **A Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted in by the funeral director. Page 2 should be detacted in by the funeral director.	Complete							20.51			1 Ye	as an itopsy erformed? es 2	pri de		opsy findings available impletion of cause of 2 No
Vital hysician: this certifit of Be C	ן מ	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1	Inpatient	2 🗸 EI	R/Outpatient			of Death (Home 5	Resid	lence 6	Other:	
ion of Vi tending Physi eath. tor: After this the funeral di		7. Manner of Death 1 Natural 5 Pend	(Date of Injury (Month, Day,Year)) 2	8b. Time of In	jury 2	28c, Injui	ryat Work? /es 2 l				nju ry оссите	d	
Division o Boptal ar Attending 24 hours after death 25 Hours after death 26 hours divined by the func- sely filled in by the func- al Certification:		Suicide 6 Could determ	not be 28e.	. Place of Injury ecify)	y - At hom	e, farm, street	, factory	office b	uilding, etc			n (Street n, State)	and Number	or Rur	al Route Number, City
To the Hos within 24 h To the Fun completely		One on only	niner: On the b	ne best of my ki pasis of examin nner stated.	_										
(1) (1) (1) (1) (1) (1) (1) (1) (1) (1)	2	9b. Signature and title of certifier		10	n		290	. Licens	e number VI.E.				Date signed		th, Day,Year)
FOI	3	O. Name and address of person Carol Allan, MD Ass		cause of deal			more S	Street,	Baltimo	re, M	21223	•			
State Registra	_	11. Date filed (Month, Day, Year)	A. S	32. Registrar's	Signature										

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 1,2012 9am January Geety Mary /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examine Prince George Laurel Cherry Lane Nursing Home Date of Birth (Month, Day, Year 3/7/1920 9. Birthplace (State or Foreign Country) If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Days Months Min Hours 1 □ M 2√√ F 91 VA 579-28-1364 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location r 28a-f show notified at 1 □ Yes XX No Prince George Laurel Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number d other than "natural", or items 23a or event, the Medical Examiner must be 20708 USA 9001 Cherry Lane Funeral Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXXNo White Specify Specify: \$ 3 Vidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Pages 1 and 2 should be filed withinnent of Health and Mental Hygiene.
ant: If Item 27 is marked other than ury or other traumatic event, the M Hospital Center Cashier 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ashbey Scott Beaulah Coby 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hanover, MD 21076 permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tr 1902 Waylene DR. Harry Geety III 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🔀 🛣 rial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 1/6/2012 | Brentwood, MD Ft. Lincoln Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licens Hardesty Funeral Home, P.A. Oat 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** -Oronar Edr /Medical Due to (or as a consequence A) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as the attending IF FEMALE for use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 Ø No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy performe 2 12 No 10 Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2[]No 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ this funeral 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manper of Death 28c. Injury at Work? Certification: After (Month, Day Year) 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide 29a. Certifier Medical

Hospital or Attending To the Hospital or Autonomics within 24 hours after death.

To the Funeral Director After a control of the funeral Director After Afte

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State

Registrar

31. Date filed (Month, Day, Year) JAN 05

and address of person who completed cause of death (Item 23a) (Type, Print)

igen Rd, Ellicett

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2012^{Year} Physician/ 11:30 p M Sharon Mary Gray January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Heartlands Senior Living Village Howard Ellicott City 8. Date of Birth
(Month, Day, Ye.
Aug 11, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign . Social Security Numbe 7. Age (In vrs. last birthday) Funeral 6. Sex 1 - M 2 X F Months Days Hours Min Mary Land 75 213-32-3228 Director 1936 Usual Residence of Decedent or 28a-f show 10a. State 10d. Inside City Limits death with the Maryland Examiner must be notified at 10c. City. Town or Location Director 1 🗆 Yes 2 🗙 No Westminster Maryland Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21157 "natural", or items 23a 1724 Peppermint Lane USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: white 3 Widowed 4 Divorced Completed other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) Government Claims Adjuster Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic event Dorace Lepson Herman Gray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 1724 Peppermint Lane, Westminster, MD 21157 Gail Schreiner, daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place)
All Faiths Crematory 1 Burial 2 Cremation 3 Removal from State Manchester, MD 01/05/2012 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Myers-Durboraw Funeral Home Signature of Funeral Service Licensee intou 91 Willis Street, Westminster, MD 21157 Part J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ARDIAC disease or condition Medical resulting in death) **Examiner** ESPI CHROMIC Securitially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine DIZENZE To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) resulting in death) Last ARE Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 - Fetal death in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death the g Unknow been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Yes 2 within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 No Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 2 140 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury 28b Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) PHYSICIAN Wil MAT 0062704 2012 03 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 RO

Registrar DHMH 17 Rev 7/2009

State

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31 Date filed (Month.

Day, Year)

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32. Registrar's Signature

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12-00440 Bonnie Turner (Gibs	on State o	Print in Black Inc f Maryland / Depar	rtment of	Health an			egible		0.0166
Dhusis	/	1- For State Registrar 1. Decedent's Name (First, Middle,Last)	Cert	tificate of	Death		2. Date of De	Reg. No.	201	2 0150
Physici Medical Exam		Bonnie Turner	Gibson				Month January		Year	3. Time of Death 1735 hrs
		4a. Facility Name (if not institution, give s	street and number)	4	b. City, Town, or	Location of Death	candary		. County of Death	
		Calvert Memorial Hospital	1550.18		Frederick		I. 6		Calvert	
Funeral Director			7. Age (In yrs. las		If Under 1 Year Months Day		8. Date of E		DD/YYYY) 9. Bir Foreig Co	
any		Usual Residence of Decedent 10a. State 10b. County	10c. City, T	Town or Location	n					10d. Inside City Limits
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Maryl	Director	10e. Street and Number			10f. Zip Code			-	zen of What Cour	
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked atther than "natural", ar items 23a or 28a-f sho injury ar rither traumatic event, the Medical Examiner must be notified at once.	Funeral	1 Never Married 2 Married	12. Was Decedent Ever in U.S Armed Forces?1 Yes 2 X No			spanic Ongin? (Spe n, Mexican, Puerto F		lo-	14. Race - Ameri White, etc.	can Indian, Black,
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21215-0036 und be filed within 7 Mental Hygiene. marked other than c event, the Medica		17. Father's Name (First, Middle, Last) Franklin Percy Tur	nor Cr			18.Mother's Name (
212 212 uld be Menta market	To Be	19a. Informant's Name/Relationship (Type		19b. Mailing	Address (Stree	Bonnie of Ruet and Number or Ru				Zin Code)
MD d 2 sho lth and a 27 is numati		Kayla Jo Turner -	Daughter	i .		ngs Road,				
s l and f Heal If item		20a. Method of Disposition 1 X Burial 2 Cremation 3			on (Name of cer		Date		Location - City or	
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Ball permit Depart Impor		21. Signature of Funeral Service Licenses			me and Address	1100			al Home,	
Physician		23a. Part I. Enter the disease, or complica	ations that caused the death. D			such as cardiac or r				Approximate Interval
/Medical Examiner		failure. List only one cause on each Immediate Cause (Final disease a	_{line.} Atheroscleorti	.c cardi	Lovascul	lar diseas	se			Between Onset and Death
	Н		e to (or as a consequence of):							
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760 ficate g phys	/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregna	incy					I. Date of delivery	
Box 68760 e death certificate b the attending physi ed for use as the bu	Physician/Medical		Pregnant at time of deatl	, ~ H	Ideath 3 [er (Specify)	Ectopic pregnand	СУ	1	Month D	ay Year
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ital Recician: The secrificate rector, page		25. Was case referred to medical			26.Place	of Death (Check on	1 Yes	2 No	1 Ye	s 2 No
Vits bysicia	8	examiner? 1 ✓ Yes 2 No	oital: 1 Inpatient 2 🗹 E	R/Outpatient	en I	Other		Resider	nce 6 Other:	
Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be	Ë	27. Manner of Death 1 X Natural 5 Pending	28a. Date of Injury 2 (Month, Day,Year)	8b. Time of Inju			8d. Describe	how inju	ry occurred	
Atten r death ectur: by the	cati	2 Accident Investigation	28e. Place of Injury - At hom	o form street		es 2 No	Of Leasting	Ctan at a	d North and Do	-1.0
Divis pital or At ours after d neral Direct filled in by	Certification:	3 Suicide 6 Could not be determined	(Specify)	ie, iaim, sireei,	ractory, office bi	uliding, etc.	or Town,		a Number of Rur	al Route Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital nr Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Directur: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the built		29a. Certifier (Check only 1 Certifying Physician:	To the best of my knowledge,	, death occurre	d at the time, da	ate and place, and di	ue to the cau	se(s) and	d manner as state	d.
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medicai Examiner: Or an	the basis of examination and d manner stated.	/or investigation	n, in my opinion,	, death occurred at t	he time, date	and pla	ce, and due to the	cause(s)
	2	29b. Signature and title of certifier	111		29c. License				ate signed (Mon	
	-	30. Name and address of person who com	pleted cause of dooth (the Co	32)	O.C.N	VI.E.		Jant	ıary 16, 2012 ————	
			ief Medical Examiner	•	iltimore Stre	et, Baltimore, N	MD 21223			

31. Date filed (Month, Day Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State		State of Ma	arylan	•	artmen <i>tificate</i>			Mental H		0016	0100		
			Registrar 1. Decedent's Name (First, A	liddle, Las	t)			imour	010	-	2. Date of I		2011	3. Time of Death		
	Physicia Medio		Loi				Gur	nick			Janua	ry (9, 2012 Year	8:25 A		
	Examir	ner	4a. Facility Name (if not instituted)		·			4b. City, Town, or Location of Death					4c. County of Death			
	Funeral		Heritage Ha 5. Social Security Number	f Dor			st birthday)	Anı If Under		If Under 24 Hr		3irth	Anne Art	undel thplace (State or Foreig		
	Director		431-32-0949		□ M 2 🗶 F	89	Yrs.	Months	Days	Hours Mir	Apr 2	9av, Yea, 5	1922	AK		
	at	or	Usual Residence of Deceder 10a. State 10b. Co			10c. City	, Town or Loc	cation						10d. Inside City Limit		
	Maryla 18a-f tiffied	Funeral Director	MD C	alver	t	Dun	kirk							1 🗆 Yes 2 🕱 N		
	a or 2	a Di	10e. Street and Number					10f. Zip				10g.	Citizen of What C	ountry?		
	th with ms 23 must	ner	10634 Fielde	r Cou						754			USA			
21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 □ Never Married 2 □ 3 🏝 Widowed 4 □ Divi		12. Was Decedent E Armed Forces? 1 ☐ Yes 2 🛣 If Yes, Give Year or Dates.			Vas Deced Yes, spec			Specify Yes or N to Rican, etc.)	0-	14. Race - Ame Black, Whit Specify: W			
15-(72 hou n "nati ledica	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Busines (Specify only highest grade completed) (Give kind of work done during most of working							Industry						
212	within jiene.		Elementary/Seconday (0-12) College (1-4 or 5+) life. DO NOT use retired) Homemaker Own Home							2						
nd	filed val Hyg	Be	17. Father's Name (First, Mic	dle, Last)						18. Mother's Na	ame (First, Midd	le, Maide				
Maryland	uld be I Ment narke natic	욘	Orvia				Hine				garet			Pharr		
Ma	2 sho Ilth and 27 is r r traun		19a. Informant's Name/Rela Linda Firm				l .				ural Route Num)unkirk,		or Town, State, Zi 20754	p Code)		
re,	1 and of Hea f item		20a. Method of Disposition			20b. Pl	lace of Disposemetery, crem	sition (Nam	ne of		Date Date		Location - City or	Town, State		
Baltimore,	Page ment tant: It		1 🔀 Burial 2 □ Crema 4 □ Donation 5 □ Ot				cred H	eart	Cem.	Jar	14 201	2	Jeannette	e PA		
Ball	permit. Page 1 a Department of F Important: If ite any injury or ot once.		21. Signature of Funeral Ser		off		22				ee Funer Lane C		Home Cal	vert, PA 20736		
	Medical Medical Examiner	ler	shock, or heart failure. List only one cause on each line calcula C Interval Bet Onset and								Approximate Interval Between Onset and Death					
092	icate be executed g physician and is the burial-transit	ledical Examiner	cause. Enter Unceriying Cause (Disease or linjury that initiated events resulting in death) Last	J	C. Due to (or as a	a consequ	ence of):									
Box 68	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. Within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending p completed filled in by the funeral director, page 2 should be detached for use as to completed filled in by the funeral director, page 2.	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		23c. If yes, outcome of 1 Live Birth 4 Pregnant at 9 Unknown	2 🗌 Fetal	death 3	Ectopic p Other <i>(sp</i>					23d. Date of de Month	elivery Day Year		
ds, P.O.	quires that ten	ρ	Part II. Other significant co	nditions co	ntributing to death b	ut not resu	ulting in the u	nderlying o	cause give	n in Part I.				the cause of death?		
of Vital Records,	r: The law re icate has be r, page 2 sh	Completed	OS W								pe 1 ☐ Ye	as an topsy rformed' s 2	prior to death?	Itopsy findings available completion of cause of s 2 \square No		
/ita	s certif	To Be	25. Was case referred to med examiner? 1 Yes 2 No	-	Hospital:	nt 2 🗆 I	ED/Outpotion	· 2 □ 50	Other	e of Death (Ch		-1-1	0 - 01	-16.1		
on of \	nding Phy ath. : After this e funeral c	Certificate: T		1 Natural 5 Pending (Month, Day, Year) injury work?												
Division	ital or Atterns after de al Directored in by the			ould not be stermined	28e. Place of Inju building, etc			et, factory,	, office		28f. Location City or T		and Number or Ru ite)	rai Route Number,		
	the Hospi thin 24 houth	Medical	(Check 2 L Medi only one) 3 Certi	cal Examir lying Nurs	ician: To the best of a ner; On the basis of exe e Practioner : To the I	camination	and/or investi	gation, in r	ny opinion red at the i	death occurred ime, date and p	at the time, date	and pla the caus	ice, and due to the se(s) and manner as	cause(s) and manner sta stated.		
	, , ,)		29b. Signature and title of ce		A	4. 7:		D	License r	528		29d. I	Date signed (Mont	h, Day, Year)		
	LW 3 Stat		30. Name and address of pe Adityo Chi 31. Date filed Month, Day, Ye	pra	ompleted cause of de	Rid	gely	Ave:	SKZ	31 Ani	rapel	is h	ND 214	101		
	Registra	_	JAN 1 U 20	2 6	news A	A	a. a/ f									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 $a^{\,\text{M}}$ Barbara Furbish Geyger January 10:05 **Medical** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sunrise Assisted Living Silver Spring Montgomery Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday) Hours (Month, Day, Year) 039-20-3784 **Director** 1 M 2 🔼 F 80 Nov. 27, 1931 Rhode Island Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location with the Maryland must be notified at Director 1 🗌 Yes 2 🗵 No MD Montgomery Silver Spring 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 20904 11621 New Hampshire Ave., Apt. 216 USA ral", or items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black White etc þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Specify White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. "natural", 3 X Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Librarian Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ George H. Furbish Ruth Harriet Crocker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Bond Baily, Jr./Executor 411 Lexington Drive, Silver Spring, MD 20901 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Jan. 2012 Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA 22. Name and Address of Facility
Francis J. Collins Funeral
500 University Blvd. W., S 21. Signature of Funeral Service Licensee Home Inc pring. MD 20901 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Cardiorespiratory Arrest disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Alzheimer's Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending housing and Breast Cancer E L that initiated events Due to (or as a consequence of) resulting in death) Last signed by the attending physician d be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month 5 Other (specify) Pregnant at time of death 1 Yes 2 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown ate has been signated bage 2 should b 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

1 Yes 2 No mpletely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Assisted Living Hospital 1 Tes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🗷 Natural work?
1 Yes 2 No iniurv 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🖺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one

State Registrar 29b. Signature and title of

Jean Welsh, MD

31. Date filed (Month, Day, Year) JAN 05 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10801 Lockwood Drive, #310, Silver Spring, MD 20901 32 Registrar's Signature

29c. Lice

Month, Day, Year)

29d, Datels

12-00010 W	VVI VVI	Please Type or Print In BI					gible.	
ANK ANK CO	illac	State of Maryland	Department // Department // // // // // // // // // // // // //		nd Mental F	-	2013	2 0168
Physic Medical Exam						2. Date of Dea	Day Year	3. Time of Death 0302 hrs
Medical Exam	iner	Kaitlin Marie Gallagher 4a. Facility Name (if not institution, give street and number)	-	4b. City, Town, o	r Location of Dea	January 1	4c. County of Death	
		Jones Bridge Rd and Lancaster Dr		Bethesda	Tall and		Montgomery	
Funeral Director		212-47-6133 1_M 2AF	e (In yrs. last birthday	Yrs. If Under 1 Yes Months Day			rth(MM/DD/YYYY) 9. Bird Foreig / 1993	
any		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
fand f show	tor	DC	Washingt					1 XYes 2 No
th the Mary 13a or 28a 10tified at	Il Director	10e. Street and Number 4815 43rd Street NW		10f. Zip Code 20016			Og. Citizen of What Cour	tes
eath wil	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2		Was Decedent of Hi If Yes, specify Cuba			14. Race - Ameri White, etc.	can Indian, Black,
after d	by Ft	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1	Yes 2 X No			Specify: Whit	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland beaperment of Health and Mental Hygiene. Important: I filem 71 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	15. Decedent's Education (Specify only highest grade com Elementary/Secondary (0-12) College (1-4 or 5)	5+) durin	edent's Usual Occupa ng most of working life cudent			16b. Kind of Business/l	
21215-0036 Auld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be Cor	17. Father's Name (First, Middle, Last) Eugene James Gallagher			Anita I	rmeli H		
MD 2, 12 should th and M a 27 is m	2	19a. Informant's Name/Relationship (Type, Print) Eugene Gallagher / Father					mber, City or Town, State ton, DC 200	
re, N s 1 and of Health If item		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from Sta		sposition (Name of ce or other place)	metery,	Date	20c. Location - City or	Town, State
Baltimore, permit. Pages I an Department of Hee Important: If ite injury or other tr		4 Donation 5 Other Specify: 21. Signal re of Fineral Service Licepsee	National	Cremator			Falls Chu: wler's Sons	
Bal permi Depar Impo		21. Signature of Funeral Service Licensee					shington, Do	
Physician		23a. Part I. Enter the disease, or complications that caused failure. List only one cause on each line	the death. Do not ent	ter the mode of dying	, such as cardiac	or respiratory am	rest, shock, or heart	Approximate Interval Between Onset and
≛xaminer		Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Due to (or as a conse	equence of):					Death
	ner	Sequentially list conditions, if any, leading to immediate Due to (or as a conse	equence of):					
pa	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conse	equence of):					
e executed an an	lical	d. UNPENDED AMENDED						
3760, ficate by g physic s the bur	cian/Medical	IF FEMALE: 23c. If yes, outcon 1 Live birth		Fetal death 3	Ectopic pregr	ancy	23d. Date of delivery	Day Year
Box 68760, e death certificate be execut the attending physician arred for use as the burial - tran	Physicial	past 12 months? 4 Pregnant at 1 Yes 2 No 9 Unknown 9 Unknown	time of death 2 1	Other (Specify)		idiloy	World	ay 16a)
P.O. es that the igned by t	<u>\$</u>	Part II. Other significant conditions contributing to death	but not resulting in the	he underlying cause	given in Part I.		obacco use contribute to s	
rds, require to be si	leted	-				24a. Was autor		topsy findings available ompletion of cause of
Reco: The law	Completed	25 W		00.01	of Double (Observe	perfo 1 Yes	rmed? death?	
Vital rysician this cert	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatie	nt 2 ER/Outpat		of Death (Check Other Nurs		Residence 6 🗸 Other	Scene
on of nding Pl .th. r: After	ion: T	27. Manner of Death 1 Natural 5 Pending 28a. Date of Inju (Month Day, Y) Jan 1, 2012	ry 28b. Time ear) 0251 hrs	· · · ·	ıry at Work? Yes 2 ✓ No		how injury occurred in motor vehicle co	llision
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. UTo the Functor: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burit	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Loc	ury - At home, farm, s	street, factory, office I	ouilding, etc.	or Town, S	Street and Number or Rui State) Rd and Lancaster Dr,	
To the Hosp within 24 hos To the Fune completely fi	Medical C	29a. Certifier (Check only qfie) Certifying Physician: To the best of my qfie) 2 Medical Examiner: On the basis of exam	_					
Transport of the state of the s	Me	29b Signature and title of certifier		29c. Licens			29d. Date signed (Mor	oth, Day, Year)
		((a lule en)		O.C.	M.E.		January 1, 2012	
		Name and address of person who completed cause of data. Laron Locke MD. Assistant Medical Example 1.2 Assistant Medical Example 2.2 Assistant Medical Exam		Baltimore Stree	et, Baltimore,	MD 21223		
S Regis	tate trar	31. Date filed (Month, Day, Year) 22. Registral	's Signature	Jed.				

DHMH 17 Rev 1/2001 OCME 2006

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		for State Registrar	State of N	Maryland ,		artment of F	Health a		ental Hyg		12	0 1	687
Physici Med		1. Decedent's Name (First, Middle	, Last) LEE	GROSS					2. Date of Dea	th		3. Time o	
Exami	H	4a. Facility Name (if not institution) FREDERICK MEM	ORIAL HOSPI	TAL		4b. City, Town, o	ICK			4c. County FRED	of Death		
Funera Director		5. Social Security Number 213–46–0757 Usual Residence of Decedent	6. Sex 1 □ M 2 🕱 F	nge (In yrs. last t	Yrs.	If Under 1 Year Months Days	If Under 2 Hours		8. Date of Birth		9. Birthp Mary	lace (State of	or Foreign
Maryland :8a-f show tifie d at	rector	10a. State 10b. County Maryland Frede	rick	10c. City, To	own or Lo	cation k			-		11	Od. Inside C	ity Limits
with the I s 23a or 2	Funeral Director	10e. Street and Number 424 Pinoak Pl	ace			10f. Zip Code 217	01			10g. Citizen of USA	What Count		
ire, Maryland 21215-0036 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. The stream of the stream "natural", or items 23a or 28a-1 show other traumatic event, the Medical Examiner must be notified at		11. Marital Status 1 🔀 Never Married 2 🗌 Marr 3 🗎 Widowed 4 🗎 Divorced	ied 12. Was Decedent Armed Forces 1 Yes 2 If Yes, Give Year or Dates.	?		Vas Decedent of Hi f Yes, specify Cuba		in? (Spec Puerto R	ify Yes or No- ican, etc.)		e - America ck, White, e		
Baltimore, Maryland 21215-0036 bernit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. "mportant: If item 27 is marked other than "natural", on any injury or other traumatic event, the Medical Exam proce.	Be Completed by	(Specify only highe Elementary/Seconday (0-12)	t's Education st grade completed) College (1-4 or	5+)	(Give I life. D	lent's Usual Occup. kind of work done of O NOT use retired) person	ation during most	of workin	g	16b. Kind of B		,	ies
Maryland should be filed and Mental H is marked ot raumatic ever	To B	17. Father's Name (First, Middle, L Leland Gros	S						(First, Middle, M Seaton	Maiden Surnam	e)		
e, Mal and 2 sho Health and tem 27 is n		19a. Informant's Name/Relationsh Susan Holton -		62	20-B	g Address (Street a Research	Court	or Rural . Fi	Route Number, cederic	City or Town, S k, Mary	State, Zip Ci 1and	2170	3
Baltimore, permit. Page 1 and 1 Department of Healt Important: If item 2 any injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 4 ☐ Donation 5 ☐ Other (S)	pecify)	e ceme	^{tery, cren} 1ffer	sition (Name of natory or other place Cremato	ry I	1-5-2	2012	20c. Location Frederi	ck, M		nd
Dermi Permi Depar Impol		21. Signature of Funeral Service L	mule ?	Eleve	ر 16	Name and Addres	umtowi	n Pik	ce, Fred	derick,		land	21702
Physician/ Medical Examiner		23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a. Prev	ed the death. Done.		r the mode of dying	g, such as c	ardiac or	respiratory arre	st,		Approximat Interval Bet Onset and I	ween
te be executed hysician and he burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause. Enter Underlying that initiated events resulting in death) Last	c	a consequence									
DIVISION OF VITAIN RECORDS, F.O. BOX 68/600 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. The Tuneral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetal dea	ath 3 🗆	Ectopic pregnancy Other (specify)	у			23d. Da	te of deliver		/ear
ds, F.C. quires that the sn signed by and be detach	by	Part II. Other significant condition	ns contributing to death	but not resulting	g in the ur	nderlying cause give	en in Part I.		23e. Did tob	es 2 No		cause of d	
II KECOTGS, n: The law requires fifcate has been sig or, page 2 should b	e Completed	25. Was case referred to medical								y need2	Were autops prior to com death?	y findings a pletion of c	available ause of
OI VICAL Ig Physician: ter this certific neral director,	To B	examiner? 1 Yes 2 No 27. Manner of Death	Hospital: 1 Hospital: 28a. Date of inju	ient 2 ER/C	Outpatient	3 ☐ DOA Othe	4 L Nurs	sing Hom	e 5 🗌 Reside	nce 6 Othe			
DIVISION OF VITAL RECCI To the Hospital or Attending Physician: The law within 24 hours after deadth. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2.	Certificate:	1 Natural 5 Pending 2 Accident Investig: 3 Suicide 6 Could n 4 Homicide determin	(Month, Da	ury - At home, f	injury		Yes 2 N	10	_	w injury occurre		oute Numb	er,
Hospital 24 hours Funeral eted filled	Medical	Check 2 Wedical Ex	Physician: To the best of aminer: On the basis of a	examination and	Or Investi	dation in my opinior	a death acci	urrad at th	a tima data an	d wlood and disc		-/-/	nner stated.
To the within To the comp	2	only one) 3 Certifying I 29b. Signature and title of certifier	Nurse Practioner: To the	Dest of my know	wledge, de	29c. License	time, date a	nd place,	and due to the	Pd. Date signed	nner as stat	ed.	
2		30. Name and address of person w	ho completed cause of c	death (Item 23a)	(Type, Pr	int) A F	reder	ict,	MO 20	201	111		
Sta Registra	ar	31. Date filed (Month, Day, Year)	2012 32. Begistr	ar's Signature	p	arkel							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Mar	yland /	•			id Ment	tal Hygie	ene			_
			State Registrar			Cert	ificate of D	eath		Reg	g. No. 2	12	01688	3
	Physicia Medic		1. Decedent's Name (First, Middle, Last)		Ge	art	art			ate of Death	9 Day 201	Year	3. Time of Death 440 A M	
	Examin		4a. Facility Name (if not institution, give s	treet and number)			4b. City, Town, or Haac	-	eath WM		4c. County o		100	
	Funeral Director		5. Social Security Number 6. Sex	7. Age (la	n yrs. last bin		If Under 1 Year Months Days	If Under 24	Hrs. 8. D	ate of Birth Month, Day, Yo		g. Birthp	ace (State or Foreign	_
			Usual Residence of Decedent	· · · · · · · · · · · · · · · · · · ·					JJu.	ly 4,	1933	магу	rand	_
	/land f sho	ţċ	10a. State 10b. County	1	0c. City, Tow	n or Loca	tion					10	d. Inside City Limits	
	Mar 28a- lotifie	Director	MD Washing	ton 1	Maugan	svi1							1 X Yes 2 ☐ No	
	with the 23a or ast be r	Funeral D	10e. Street and Number 14011 Village Mil	l Dr.			10f. Zip Code 21767			10	g. Citizen of Wh		ry?	
	leath items er mu	Fun	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.		as Decedent of His				14. Race	- America		_
21215-0036	within 72 hours after death with the Maryland giene. ter than "natural", or items 23a or 28a-f sho to the Medical Examiner must be notified at	sq pa	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🏿 Divorced	1 X Yes 2 No If Yes, Give Year or Dates.			'es, specify Cubar ☐ Yes 2🌠 No		uerto Rican,	, etc.)	Black, Specify:	White, e		
2-0	2 hour "natu	blet	15. Decedent's Edu (Specify only highest grad		16a	. Decede	nt's Usual Occupa nd of work done di	ition	working	16	6b. Kind of Bus	iness Ind	ustry	
12	within 72 giene. ler than t, the Me	Completed	Elementary/Seconday (0-12)	College (1-4 or 5+)		life. DO	NOT use retired) Lft Opera		WOIKING		Manufac	turi	ng	
	lled wi	Be	17. Father's Name (First, Middle, Last)	_	1 - `	JI KI.	The opera		Name (First		iden Sumame)			_
ylan	should be filed and Mental Hy, is marked oth raumatic event	မ	Irvin Ward Gearha	ırt							Durbin			
Maryland	d 2 shou alth and 27 is m		19a. Informant's Name/Relationship (Type Douglas E. Gearhar				Address (Street a						ode)	
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 X Burial 2 Cremation 3 F	Removal from State	cemete	ry, crema	tion (Name of tory or other place		Date		Oc. Location - C			
탪	permit. Page Department Important: II any injury or once,	-	4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses		nest n	_	Cemeter		14/20 Rest		Hagerst			-
ŭ	Depar Depar Impor any in		> S. Muck Su	160			01 Penns	-					_	
	Ph_sician/		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only one Immediate Cause (Final	cations that caused the cause on each line.	e death. Do r	Person N		, such as card	diac or resp	iratory arrest	,		Approximate Interval Between Onset and Death	
	Medical Examiner		disease or condition resulting in death)	ue to (or as a co	onsequence		147	21500	150					_
	D #	niner	Sequentially list conditions, if any, leading to cause. Enter Underlying	Due to or as a co	onsequence	of)								_
	death certificate be executed re attending physician and ed for use as the burial-transit	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	Due to (or as a co	onsequence (of):								_
09,	ate be o	edical		l										_
89		n/Me	IF FEMALE: 23b. Was decedent pregnant 23	Bc. If <u>ye</u> s, outcome of j	pregnancy						23d. Date	of delive	n/	
		Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live Birth 2 4 Pregnant at tir 9 Unknown			Ectopic pregnancy Other (specify)	/			Mont		Day Year	
P.O.	law requires that the de ras been signed by the.	by Ph	Part II. Other significant conditions con	tributing to death but r	not resulting i	in the und	lerlying cause give	en in Part I.	2	3e. Did toba	cco use contrib	ute to the	e cause of death?	_
ds,	equires en sig ould be				-				_	1 🗌 Yes	2 🗆 No 3	□ Prob	ably 4 Unknown	
Vital Records,	sician: The law re s certificate has be lirector, page 2 sh	Completed							_	24a. Was an autopsy performe	pri	or to con ath?	sy findings available apletion of cause of	
표 등	an: Th tificat tor, pa	Be Co	25. Was case referred to medical				26. Pla	ce of Death (C			No 1	Yes	2 🗆 No	-
<u> </u>	ysician: is certific director,	To B	examiner? 1 \(\sum \) Yes 2 \(\sum \) No	ospital: 1 lnpatient	2 🗌 ER/OL	utpatient	Otho	r			ce 6 🗆 Other	(Specify)		П
n of	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Yo		Time of njury	28c. Injury work? M 1 🗆	at	28d. D		injury occurred			
Division of	or Atter ifter dea Sirector in by the	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (S	- At home, fa Specify)	rm, stree			28f. Lo	ocation (Streetity or Town, S	et and Number State)	or Rural i	Route Number,	
בֿ	ospital hours a uneral C	edical (29a. Certifier 1 Certifying Physic	cian: To the best of my	knowledge,	death oc	cured at the time,	date and plac	ce, and due	to the cause	(s) and manner	as stated	i.	- 1
	the H ithin 24 the Fι impletε	Me	(Check 2 Medical Examine only one) 3 Certifying Nurse	Practioner: To the bes	st of my know	r investig ledge, dea	ation, in my opinior ath occurred at the 29c. License	time, date and	red at the tin d place, and	due to the ca	iuse(s) an d mani	ner as sta	ted.	a.
	F ≥ F 8		I hophanie (ona Conc	volla	CKi	0.0	574°	8	290	Date signed (09	2012	
TU.	-5+1		30. Name and address of person who con	mpleted cause of death	h (Item 23a) (Type, Prin	14 214 M	arsh t	Pilce	Marcis	Hown	MD	21742	
	Stat Registra		31. Date filed (Month, Day, Year) 1 20	32. Fegistrar's	Signature	60	vel.)				_

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. / 1. Decedent's Name (First, Middle, Last) 2. Date of Death 5129AM Month Physician/ 2012 Ronald Lee Gelwicks, Sr. Januar Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hagerstown Washington Meritus Medical Center 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Sept.9,1939 Months Maryland **Director** 215-36-6192 1 X M 2 🗆 F 72 Usual Residence of Deced or 28a-f show notified at 10d. Inside City Limits 10b County 10c. City, Town or Location within 72 hours after death with the Maryland 1 Wester Director 1 Yes XXNo Falling Waters Virginia Berkeley 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5 "natural", or items 23a o Funeral USA 25419 134 Left Street Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

XX Yes 2 No 1959If Yes. Give Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. Specify White Completed 3 Widowed 4 Divorced 1962 Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene.
is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Aluminum Manufacturer the Truck Driver Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ruth Rayetta Rummel Joseph Francis Gelwicks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Heatth ar Important: If item 27 is any injury or other trau 134 Left Street Falling Waters, West Virginia 25419 Dorothy J. Gelwicks-Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Mem. Park | Jan. 12, 2012 | Hagerstown, Maryland Osbornea Guneral Home, P.A. 21. Signa re of Funeral Serv 425 S. Conococheague St.Williamsport, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic Ph_sician/ YEAR disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine death certificate be executed and Due to (or as a consequence of): resulting in death) Last burial physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 as. IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 L Fetal usa Pregnant at time of death 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) Yes 2 No the 9 Unknown signed by to d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? Yes 2 No death' 1 Yes 2 No After this certificate I 26. Place of Death (Check only one) **Director:** After this certification in by the funeral director, 25. Was case referred to medica Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XNo 1XInpatient 2 ER/Outpatient 3 DOA မှ 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 27. Manner of Death Certificate: I or Attending Fafter death. 1 X Natural 5 Pending Investigation 6 Could not be Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined Hospital 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (*Month*, *Day*, *Year*) 29b. Signature and title of certifie D 68995 pe and address of person who completed cause of death (Item 23a) (Type, Print)
Ing Tang, ~0 1130 Opal Ct, Hagerstown, ~0 21740 1+P Cir State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Q n Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ E. Hilda Goranson 2012 5:05A January Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Somerford Place Assisted Living Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth 6. Sex Age (In vrs. last birthday) **Funeral** (Month, Day, Months Days Hours 1 □ M 2 🕱 Maryland 578-14-8344 94 1917 Director Dec. Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State the Maryland Director MD Prince George's Suitland 1 Yes 2 X No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral United States permit. Page 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a 20746 5412 Medford Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Yes 2 X No þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify White 3 X Widowed 4 Divorced Completed event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 U.S. Government 0 Secretary Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Cora Hawkins Guy Howes other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 8402 Heatherwood La., Pasadena, Maryland 21122 John R. Goranson / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) injury or 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Department of Importants If any injury or 1/4/2012 Laytonsville, MD Laytonsville Cem. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Muriel H. Barber Funeral Home) OR Laytonsville, Maryland P.O. Box 5038, Part 1. Extent the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Dementi Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying burial-transi Cause (Disease or liniury and that initiated events Due to (or as a consequence of) resulting in death) Last signed by the attending physician d be detached for use as the burial Physician/Medical death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 1 ☐ Yes ∠ ⊑ 9 ☐ Unknown 9 Unknown • Hospital or Attending Physician: The law requires that the 24 hours after death.
• Funeral Director: After this certificate has been signed by the leted filled in by the funeral director, page 2 should be detached. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 🗷 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 🗹 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Assisted Living Hospital မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 M Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at work? Natural 5 Pending injury 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 To the I only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

san'

millersville mo. 21108

Scol ve te

Registrar's Signature

pandov

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32.

00

oth, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Sophie GUGGENHEIM 2012 11:42 A M Medical January 4a. Facility Name (if not institution, give street and number) **Examiner** City, Town, or Location of Death . County of Death Montgomery #1303 Silver Spring 1121 University Blvd., W. Social Security Number 9. Birthplace (State or Foreign Country) Bulgaria 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea **Funeral** Days Hours 1 M 2 X F 93 Director 060-22-7225 Feb 1918 4 Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 Yes 2 No Silver Spring Maryland Montgomery 10e, Street and Number 10g. Citizen of What Country? 23a Funeral 20902 United States 1121 University Blvd., W. #1303 ural", or items? 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 🔀 No Specify: Specify: white "natural", 3 X Widowed 4 Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Own Home Homemaker event, Be 18. Mother's Name (First, Middle, Maiden Syrname)
Rebecca Rabinowitz 17. Father's Name (First, Middle, Last) of Health and Mental H fitem 27 is marked of r other traumatic ever ပ Page 1 and 2 should be Albert Jordan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Department of Health ar Important: If item 27 is any injury or other trau Edmond Navarro, Grandson 18617 Reliant Drive, Gaithersburg, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Burial 2 Cremation 3 Removal from State nation 5 Other (Specify) Judean Memorial Gardens 01/09/12 4 Donation Olney, MD 21 Signata e PorchinskysHebrew Funeral Home 20012 254 Carroll St., NW, Washington, DC Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute Myocardial Infarction Physician/ disease or condition Minutes Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) and sub-Due to (or as a consequence of) resulting in death) Last burial attending physician for use as the burial Physician/Medical certificate be Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death g 🗌 Unknown be detached P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 👿 No 3 ☐ Probably 4 ☐ Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? Alzheimer's Disease 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner?

1 Yes Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 2 X No ျ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this of completed filled in by the funeral director. After this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred the Hospital or Attending I hin 24 hours after death. the Funeral Director; After 1 X Natural 5 Pending injury Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Pregioner: To the begin of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) D 09834 January 9, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20895 Barry N. Rosenbaum, M.D., 3720 Farragut Avenue, 2nd Floor, Kensington, MD 31. Date filed (Month, Day, Year) 3. Registrar's Signature

State

Registrar

JAN 1 0 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1 Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 201 Robert Dredla Grosshans January Medical 4a. Facility Name (if not institution, give street and number) County of Death 4b. City, Town, or Location of Death Examiner Prince George Regional dure. Hospita If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 1 X M 2 □ F Age (In vrs. last birthday 8. Date of Birth **Funeral** Days May 14, ^Y1923 NE Director 88 507-10-3939 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shou any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Yes 2X No MD Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20901 416 East Franklin Avenue 12. Was Decedent Ever in U.S. Armed Forces?

1 🖾 Yes 2 🗆 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Specify: Caucasian WWII Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ University Education Professor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Dredla Irma 01ga Henry Grosshans 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 416 E. Franklin Avenue, Silver Spring, MD 20901 Nancy Lou Grosshans / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/07/2012 Glen Burnie, MD Atlantic Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Thibadeau Mortuary Service, p.a.
7 Park Avenue, Gaithersburg, MD M00956 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death

Weeks Immediate Cause (Final Physician/ neumonid disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner rdiomyopath Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last burial Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 the attending phy use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live Birth
4 Pregnant a
9 Unknown in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) 1 Yes 2 L 9 Unknown the a signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Parkinsons 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ▼ No Respiratory 24a. Was an page 2 s autopsy Edema certificate Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 ☐ Yes 2 🗶 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred After 1 X Natural 5 Pending injury Investigation Accident within 24 hours after deatl

To the Funeral Director:
completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 the only one)

State

JAN 1 0 2012 Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

9101 Cherry Lane, Suite 211

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Saini

D28998

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Physician/ 20 Î 2 \mathbf{p}^{M} 5:55 Sylvia Adelsman Goss Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Hours Min (Month, Day, Year) Director 306-30-0712
Usual Residence of Decedent 1 □ M 2 🗓 F Austria 6-20-1930 items 23a or 28a-f show her must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location with the Maryland 10a, State Director 1X Yes 2 □ No Gaithersburg MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe Funeral United States 20878 150 Chevy Chase Street, Apt# 406 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S permit. Page 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner Armed Forces Black, White, etc. 1 ☐ Yes 2 💢 No If Yes, Give þ 1 Never Married 2 Married 5-0036 1 ☐ Yes 2 X No Specify: Specify. White Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Education Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maryland မ Fanny Juran Jack Adelsman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Penny Goss-Packard - Daughter 3007 Windy Knoll Ct., Rockville, Maryland 20850 Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Clarksburg, Maryland 1-8-2012 4 ☐ Donation 5 ☐ Other (Specify) Garden of Remembrance 22. Name and Address of Facility Edward Sagel Funeral Direction 21. Signature of Funeral Service Licensee MO1597 Magnethio 1091 Rockville Pike, Rockville, Maryland 20852 Melissa Greenhut 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line 4 months etas tatic Immediate Cause (Final melanoma Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner associative that eco-diffica-Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) attending physician and for use as the burial yearsif Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year Month Day 5 Other (specify) Pregnant at time of death should be detached 9 I Inknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 MNo 3 ☐ Probably 4 ☐ Unknown 1 Tes Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? page 2 autopsy performed' 1 ☐ Yes 2 ☐ No certificate Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Hospital: 1 🗌 Yes 2 XNo 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 28c. Injury at 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: work?

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

LNUARY

6099

YLVIA

State Registrar

Medical

1 Natural

Accident

Suicide

4 Homicide

only one)

29b. Signature and title of cer

31. Date filed (Month, Day, Year)

29a. Certifier

5 Pending

(nambi)

JAN 1 0 201

Investigation 6 Could not be

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

DHMH 17 Rev 06-2011

injury

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

32. Registrar's Signature

2 🗌 No

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

000 610 83

9707 Medigy Center Drive # 360, Rockville, Maryland 20854

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

January 6,

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day Physician/ Month Louis Sheldon Glover 2012 10:00 am 6, January Medical 4a. Facility Name (if not institution, give street and number, 4b. City. Town, or Location of Death Examiner 4c. County of Death Renaissance Gardens at Riderwood Villag Silver Spring P.G. 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) WV 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Days (Month, Day, Ye 1 🖾 M 2 🗆 F Months Hours 205-14-6071 Director 87 T924 Usual Residence of Decedent 28a-f show 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.
27 is marked other than "natural", or items 23a or 28a-f shortranmatic event, the Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD P.G Silver Spring 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 3160 Gracefield Road, OG-3301 20904 USA Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?
1 ♣ Yes 2 No
If Yes, Give Black, White, etc. 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify. Specify: 3 ₭ Widowed 4 □ Divorced Completed Year or Dates. WWII 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Aeronautical Engineer Applied Physics Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John F. Glover Nellie M. Thurston I and 2 should b I Health and Mei Item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louis Sheldon Glover/Son 205 Violet Court, Mt. Airy, MD 21771 item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 and Department of Hall Important: If ite any injury or ot cemetery, crematory or other place) 1 Burial 2 XCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA Metropolitan <u>Crematory</u> 21. Signature of Funeral Service License Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spri Silver Spring. MD 20901 Part T. Enter the disease, or combilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final Onset and Death Physician/ Arteriosclerotic Cerebrovascular Disease disease or condition vr Medical resulting in death) Due to (or as a consequence of) Examiner Diabetes unknown Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): requires that the death certificate be executed Due to (or as a consequence of): attending physician are for use as the burial. resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 . Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death 2 No been signed by the should be detached 9 🗍 Unknown a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Lewy Body Dementia, Chronic Kidney Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician; The law page 2 autopsy performed? Yes 24 certificate 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျ 1 ☐ Yes 2 K No 1 Inpatient 2 I ER/Outpatient 3 I DOA After this 28a. Date of injury (Month, Day, Year) . Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1X Natural 5 Pending 24 hours after death. Funeral Director: A 1 🗌 Yes 2 🗌 No the 1 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Toleted (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the F 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 0 Name and address of person who Eileen Gemmell, who completed cause of death (Item 23a) (Type, Print)

CRNP 3160 Gra 3160 Gracefield Road, Silver Spring, MD 20904

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

JAN 1 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January Physician/ Reece Alexander Goodman 0045 Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Union Hospital Ceci1 E1kt.on Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** SEPT 4. 1925 1 🏋 M 2 🗆 F Months Davs Hours North Carolina Director 246-22-2265 86 Usual Residence of Decedent 28a-f show 10b. County the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 15 Farah Drive 21921 United States 12. Was Decedent Ever in U.S. Armed Forces? World
1 X Yes 2 No If Yes, Give War II 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) should be filed within 72 hand Mental Hygiene.
7 is marked other than "n ${ t Automobile}$ Elementary/Seconday (0-12) College (1-4 or 5+) Spot Welder Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Reece A. Goodman, Sr. Lou Ellen Haire 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Edith Goodman/Wife 15 Farah Drive, Elkton, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite January injury or o 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Union Cemetery 17, 2012 Union, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ 10 40.43 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year 1 Yes 2 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Fibr. Hation Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed? Yes 2 N Cerebrovascular certificate 2 🗌 No To the Hospital or Attending Physician: 'within 24 hours after death.

To the Funeral Director: After this certifica Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural Accident 5 Pending 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year) 65902

Registrar
DHMH 17 Rev 7/2009

30. Name and address of person

31. Date filed (Month, Day,

38

ElKton

who completed cause of death (Item 23a) (Type, Print)

Carlo E. Gopez,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ALVIN REGG Januar Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Prince George Regional Hospita .dure 5. Social Security Number 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 1 🗙 M 2 🗆 F (Month, Day, uly 22 251-22-2110 86 Hours Min. **Director** July Usual Residence of Decedent 28a-f shov filed within 72 hours after death with the Maryland at 10a. State 10c. City, Town or Location Director 10d. Inside City Limits must be notified DC Washington 1X Yes 2 No 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 20032 735 Alabama Ave., Southeast United States 12. Was Decedent Ever in U.S Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iten edical Examiner 11. Marital Status 14. Race - American Indian, Black, White, etc. Š 1 Never Married 2 Married Maryland 21215-0036 1 Tes 2 No Specify: Black Completed 3 Widowed 4 Divorced Department of Health and Mental Hygiene, Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Police Officer Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ should be Archie Gregg Heniretta Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Muriel Mealing/Niece 1731 Pine Grove Blvd., Bay Shore, NY 11706 permit. Page 1 and 2 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 01/31/2012 Arlington Cemetery Arlington, VA 21. Signature of Funeral Service Licens 22. Name and Address of Facility Pope Funeral Homes, P.A. Lur 5538 Marlboro Pike, Forestville, MD 20747 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Ph sician/ Rena disease or condition Houte - Medical resulting in death) **Examiner** rindry Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Be Completed by Physician/Medical Examiner Due to (or as a consequence of Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Month Year Day Yes 2 No g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Congestive Heart Failure Division of Vital Records, 2 ☐ No 3 ☐ Probably 4 X Unknown Cerebrovascular Accident 24b. Were autopsy findings available prior to completion of cause of death? autopsy Dementia performe 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No မြ Other: 1 X Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 2 🗌 No Accident 24 hours after deat Investigation 6 Could not be ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License numbe 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7300 Munim, MI Regional Hospita State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Time of Death Month Day Physician/ LIENR 17ab Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** University Bultimore of Maryland 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** Months Hours Director 168-24-5933 79 1 🗆 M 2 🔀 F Nov 21 1932 Maryland 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Medical Examiner must be notified at Director 1 XYes 2 No MD Kent Worton 10f. Zip Code 10g. Citizen of What Country? 0 10e. Street and Numbe 23a Funeral 10564 Worton Rd U.S.A death Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Force Black, White, etc. , or þ 1 Never Married 2 Married Yes 2 No Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: White "natural", Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working (Specify only highest grade completed) than life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Homemaker Own Home Alth and Mental Hygie 27 is marked other r traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lee Layfield Margaret Beecham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trat Robert E. Gears (husband) 10564 Worton Rd. Worton, MD. 21678 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Durial 2 K Cremation 3 Removal from State 4 Donation 5 Other (Specify) Kent Cremation Services 1/16/12 Smyrna, DE 22. Name and Address of Facility Galena Funeral Home of Stephen L. Schaech M00510 118 West Cross St Galena, MD.

Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in eath) Ph_sician/ MCA Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) attending physician and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day 5 Other (specify) Pregnant at time of death been signed by the a should be detached 1 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1) dsw 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy has page 2 within 24 hours after death.

To the Funeral Director: After this certificate Yes 2 No or Attending Physician: 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes Medical Certificate: To 1. Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 Natural 5 Pending Investigation "Accident 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined the Hospital 1/KCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 06-2011

Baltimore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year)

JAN 2 3 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#20b, perFH, G923, 1/31/2012, WS State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Haile 201^{Yea} Roman 2:00 January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Kensington 3720 Nimitz Road 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Min **Director** 223-35-0535 1 □ M 2 🗶 F Usual Residence of Decedent September 15, 1940 71 Ethiopia 28a-f shov 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** notified 1 Yes 2 X No Maryland Maryland Kensington Montgomery 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? items 23a or ner must be n 3720 Nimitz Road 20895 Ethiopia permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items any injury or other tranmatic event, the Medical Examiner mu 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 X Widowed 4 Divorced Completed Ethiopian Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Haile Dereseh Atsede Wondmieneh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Haimi Shiferaw / Daughter 3720 Nimitz Road, Kensington, Maryland 20895 20a. Method of Disposition 20b. Place of Disposition (Name of Unk. Date 20c. Location - City or Town, State cemetery crematory or other place)
Medan Alem Kiraneo
Cemetery 1 X Burial 2 Cremation 3 Removal from State January 15, 4 ☐ Donation 5 ☐ Other (Specify) <u>Addis Ababa, Ethiopia</u> Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Bethesda—Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 M01360 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Liver Failure Weeks disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Liver Cancer Months Sequentially list conditions, if any, leading to immediate Examine the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and mobietly filled in by the funeral director, page 2 should be detached for use as the burlat-trapsi Cause (Disease or injury that initiated events resulting in death) Last Years Hepatitis C Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5X Residence 6 Other (Specify) 1 Yes 2 X No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at XNatural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in thy opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 only one Sertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and of certifie 29c. License number 29d. Date signed (Month, Day, Year) 5. 2012 anuary ed cause of death (Item 23a) (Type, Print) 30. Name and address of persor who co 22 South Greene Street, Baltimore, Maryland 21201 Nader Hanna, M.D. 31. Date filed (Month, Day, Year) \$2. Registrar's State JAN 06 2012 Registrar

				Pleas 1 = For State Registrar	ie Type or Print Amenb Titem State of Mary Amenb Titem	i n Black I #20a-c ,2 land / Dep #7,10e ,1 <i>Cel</i>	ndelible In 22 per FH , 6 artment of 6a , b , per rtificate of	k Ensi 924,2 Health Fif 692 Death	ure All Copi /8/2012, WS and Mental H 23, 3/14/20	ygiene Ygiene Reg. No.2	egible.	01699
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	The state of the s	Examir	ner	4a. Facility Name (if not institution, g	Hospice			imore			nty of Death	
		Funeral Director		5. Social Security Number 577-42-8536 Usual Residence of Decedent	. Sex 7. Age (In y	79 Yrs.	If Under 1 Year Months Days	If Under 2 Hours	8. Date of B Min. (Month, I Feb 1	Birth (1932) 1932		blace (State or Foreign try) Ington DC
		Varyland 28a-f shov tiffied at	rector	10a. State 10b. County MD Prin	ce Georges	City, Town or Lo	cation				1	0d. Inside City Limits 1 ☐ Yes 2 🛣 No
	į	s 23a or 2	Funeral Director	10e. Street and Number 9000 Briarcros 90000 Briarcr	t Lane Apt 12	6	10f. Zip Code 20708	3		10g. Citizen e	of What Coun	itry?
	9030	ge 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item Z 7 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	è	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates.		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🛣 No		in? (Specify Yes or N , Puerto Rican, etc.)		ace - Americ lack, White, e ify: blac	etc.
ī	9500-CLZLZ	within 72 hou giene. er than "natu , the Medica	Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12) 12	s Education grade completed) College (1-4 or 5+)	(Give life. D	dent's Usual Occu kind of work done O NOT use retired Inication	during most)		Fede		vernment
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3	, Mar	nd 2 shou ealth and m 27 is m		19a. Informant's Name/Relationship Elaine Matthe	(Type, Print) Ws - sister	19b. Maili 10	ng Address (Street 109 Goos	and Number Pond	r or Rural Route Num. Ct; Laur	ber, City or Town	n, State, Zip 0 20708	Code)
1:3D	_ ≥	permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trai		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 4 ☐ Donation 5 🛣 Other (S) 21. Signature of Funeral Service (1)	Removal from State ecify) 12 State A	tlantic	natory or other pla	y 1	Date L-28-2012 State Ana ation and	Glen :	n - City or To	, MD
	מ	6 a <u>u</u> 6 6	- 1	23a. Par 1. Enter the disease, or conshoot or heart failure. List only	emplications that caused the	70	90 Ridge	Ra	Hanover', N	D 21076	c ; ill)	Approximate Interval Between
2012	فر	hysician/ Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Magno	sequence of):	legie.	mo	Z		/	Inset pro Dath
-51-1	50 or over ited		edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conductor) Due to (or as a conductor)							
Day of	The law requires that the death certificate be	re usauticerund / the attending p ched for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 Live Birth 2 4 Pregnant at time 9 Unknown	Fetal death 3	Ectopic pregnan Other (specify)	су			Date of delive	ery Day Year
ے حلب	ecords, r.O	requires trial title bearing been signed by the attershould be detached for	þ	Part II, Other significant condition	s contributing to death but no	t resulting in the u	underlying cause g	iven in Part I	1 [Yes 2 No	3 □ Pfot	bably 4 Unknown
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	Hending Physician:	ath. r: After th	Certificate:	27. Man of Death 1 Natural 5 Pending 2 Accident Investiga		28b. Time of injury	wor	ryat k?]Yes 2 □		how injury occ	urred	1919
	~ <	2 00 0		3 Suicide 6 Could no 4 Homicide determine			eet, factory, office			(Street and Nur own, State)	nber or Rural	Route Number,
	VIV	in 24 hou he Funer pletely fil	Medical	(Check 2 Medical Exa	hysician: To the best of my ki miner: On the basis of examin urse Practitioner: To the best	ation and/or inves	tigation, in my opin	on, death oc	curred at the time, date	e and place, and	due to the cal	use(s) and manner stated.
4	١	within 2 To the I		29b. Signature and title of certifier	Panel		29c. Licens	se number	?	29d. Date sig	ned (Month, I	Day, Year)
_		(F)		John W. Ta	o completed cause of death ((Item 23a) (Type,	Print)	4	Bille	1/1/2	12/8	2
		Stat Registra		31. Date the Mont 5, 2012	32. Registrar' Si	gnatus		, , ,		9		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Lillian Ruth Harris 2012 6:07a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges 5819 31st Place Hyattsville Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) V<u>irginia</u> 1 🗆 M 2 🖾 F Months Days Hours Min. (Month, Day, Year) 8 4 1932 79 579-46-4291 Yrs **Director** Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits the Maryland 10c. City, Town or Location Director 1 Yes 2 No Dc Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò "natural", or items 23a o Funeral 736 Ingraham Street NW United States permit. Page 1 and 2 should be filed within 72 hours after death \text{Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🖾 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify Black Completed 3 Widowed 4 Divorced Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Private 12th Housekeeping Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ UnKnown Mabel Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Harris/Daughter 5819 31st Place Hyatsville MD 20782 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State Chesapeake Crematory 1/10/2012 4 Donation 5 Other (Specify) Beltsville. Maryland 22. Name and Address of Facility John T. Rhines Funeral Home 21. Signature Funeral Service 3005 12th Street NE Washington DC 20017 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) End Stare Heart Disease Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury use as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ρ in the past 12 months?
1 Yes 2 No Month Day 4 Pregnant g Unknown 5 Other (specify) Pregnant at time of death s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has l autopsy performed Yes 2 death?
1 Yes 2 No After this certificate filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 X Other (Spec Daughter's Hospital: မ 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 📉 Natural iniury 5 Pending ☐ Accident Investigation 24 hours after death Funeral Director: 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year, · Joselyne Kouchhou 063740 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jocelyn Toukep Kouatchou 7625 Wisconsin Ave. Bethesda MD 20814 JAN 1 0 2012 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) Frances Elizabeth Haylock 2. Date of Death 3. Time of Death Physician/ Januar 2012 Medical 4b. City, Town, or Location of Death Hagerstown **Examiner** Meritus Medical Center Washington If Under 1 Year If Under 24 Hrs.

Months Davs Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 577-54-9738 1 🗆 M 2 🔀 F 69 Wash., D.C. **Director** May14, 1942 Yrs 28a-f show 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland 10a. State 10b. County the Medical Examiner must be notified at Director Mount Rainier Md. P.G. 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 2 10g. Citizen of What Country? ò U.SA. Apt. 102 3313 Chauncey Pl. items 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 ☐ Married à 3altimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No Specify: "natural" Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 75 Department of Heath and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Meany Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) D.C. Dept.Housing Housing Specialist Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles Harrison Mary Harrison 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

N F Wash.D.C. 20019 19a. Informant's Name/Relationship (Type, Print) 5063 Sheriff Road N.E. Melanie Butler-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Glenwood Cemetery Jan. 17, 2012 Wash.,D.C. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Fulleral Service Licensee Robinson Funeral Home 1313 23a. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ANOMIA disease or condition resulting in death) Medical Examiner ARONIC Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury DEMENTIA the Hospital or Attending Physician: The law requires that the death certificate be executed physician and strans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 as the t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 1 ☐ Yes 2 년 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 ☐ Yes 2 ☐ No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: iniury 1 Natural 5 Pending Accident Investigation hin 24 hours after death the Funeral Director. Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year)

x 4

State Registrar 2

30. Name and address from who completed cause of death (Item 23a) Wee Print et am Street, Hagerstown,

32. Registra s Signa

DO072433

1-6-2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 8 , Day Physician/ Harley Marv Jan. 2012 В. 4:24P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Prince George's 10610 Tippett Road Clinton Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days Hours (Month, Dav. Year) **Director** 215-36-4205 1 □ M 2 🗓 F 84 March 8, 1927 Maryland Usual Residence of Deceden show or 28a-f shov notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 XXNo Prince Georges Clinton Maryland 10e. Street and Numbe 10f. Zip Code ò 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral U.S.A 20735 10610 Tippett Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Marital Status Black, White, etc. þ 1 Never Married 2 X Married Yes 2**XX**No Specify. American Indian Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working I Hygiene. life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) P.G. County Schools 2 should be filed with h and Mental Hygien 7 is marked other to Bus Driver other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Joseph Proctor Cecelia Cora Linkens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sl Department of Health an Important: If item 27 is any injury or Mary D. Proctor (Daughter) 4355 Kayak Dr. Brandywine, MD 20613 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) January 13, Donation 5 Other (Specify) Clinton, MD Resurrection Cemetery 21. Sign ure of Funeral Service Licer 22. Name and Address of Facility Lee Funeral Home, Inc. MO1555 6633 Old Alexandria Ferry Rd. Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final caranomo Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) and I-transit Exami resulting in death) Last Due to (or as a consequence of): g physician a To the Hospital or Attending Physician: The law requires that the death certificate be a within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the burn completely filled in by the funeral director, page 2 should be detached for use as the burn. Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à mom 19 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perform death? 2 🗌 No 1 🗌 Yes 25. Was case referred to medical B B 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death

1 Alatural
2 Accident 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 🗆 Yes 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D46478 -9-2012

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Suresh A. Patel, MD 7501 Surratts Rd. #307 Clinton, Md. 20735

82. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2 Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death 9. Birthplace (State or Foreign Prince hever! Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** 1 🗆 M 2 💢 F Days Min. (Month, Day, Year) Months Hours Marzyland Director 46-70-2334 21 0 -Usual Residence of Decedent should be filed within 72 hours are... and Merital Hygiene.
I is marked other than "natural", or items 23a or 28a-f show it is marked other than "natural", or items 2a or 28a-f show if ite Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral USA 3292 20018 ncoln Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 1 Yes 2 X No Specify. If Yes, Give 3 Widowed 4 Divorced Completed Black Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Porter 12 earner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ SAUDY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st.
Department of Health ar.
Important: If item 27 is any injury exercise. Motting Milson Marlbon Mi) 20172 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State cemetery, crematory or other place) 2012 4 Donation 5 Other (Specify) Liston Signature of Funeral Service Licensee Name and Address of Facility MI) 20608 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Onset and Death Immediate Cause (Final DAMAGE -Physician/ BRAIN disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner CARDIAC Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) THEREOSCUERNIC CARDIOVASUUAR DISEASE burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last ending physician use as the burial Physician/Medical 1ABETES MELLITUS death certificate be Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death
9 Unknown Month Day Year 5 Other (specify) signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ YPERZTENSION Records, 1 Yes 2 No 3 Probably 4 Onknown Completed STRUKES 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy heart performed Congestive certificate 1 Yes 2 No Hospital or Attending Physician: Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA this To the Hospital or recovery within 24 hours after death.

To the Funeral Director: After this manufacted filled in by the funeral funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28h Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Tes 2 🗌 No Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Jan 3; 2012 P0043662 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PG HU SINTA 31. Date filed (Month, Day, Year) State JAN 05 Registrar

DHMH 17 Rev 7/2009

12-00005 Jason Harley Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

son Harley			e of Maryland /					l Menta	al Hyg	iene		20	12	0170
Physicia	nn/	Registrar Amend#19ap 1. Decedent's Name (First, Middle, L	erfuneralho	me49	3/2012	Cife	R.R		12.	R Date of Dea	eg. No.	20	3	Time of Death
edical Exami		Jason Har	•						1	Month January 1	Day	Year	"	0119 hrs
		4a. Facility Name (if not institution,	give street and number)		1	-		ocation of D			4c. (County of Do		
		Rt. 210 @ Kirby Hill Roa					Washing		la			ince Geo	•	
Funeral Director			v		ast birthday)	If Un	der 1 Year ths Days	If Under 2 Hours	24Hrs, 8 Min,			Fo	Birthp reign Ţ	lace (State or Vashington
Director		Usual Residence of Decedent	M 2F	37	Yrs		<u> </u>			April	19, 1	974	Count	DC
any		10a. State 10b. County		10c. City,	Town or Locati	on		-					10	Dd. Inside City Limits
E	'n	Maryland Prince G	George's		Fort Wa	ashir	ngton						1	Yes 2 No
Maryland 282-f show d at once,	Director	10e. Street and Number				10f. Z	ip Code			1	•	Og. Citizen of What Country?		
ith the ? 23s or notifie		104 Bonhill Drive 20744									United	Sta	tes	
death with the Maryland or items 23a or 28a-f tho must be notified at once.	Funeral	11. Marital Status 1							- 1	4. Race - Ar White, et		Indian, Black,		
er dea		1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:							s	pecify: I	31acl	ζ.		
ours af	d by	or Dates:							,	ss/Indu	ustry			
6 72 bo	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use retired)							•.					
Within per the	ш	12	2		Dri	ver/	Superv					curity		
D 21215-0036 should be filed within 72 bours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f she ratic event, the Medical Examiner must be notified at once.	Be Co	17. Father's Name (First, Middle, Last) Terence A. Harley, Sr. 18. Mother's Name (First, Middle, Maiden Suma Veronica A. Proctor							urname)					
212 Ment Ment	To B	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)									p Code)			
MD d 2 sho ith and a 27 is		Grace Harley (Mot	her) (wife)						t Was	hingtor	ı, MD	20744		
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and M Important: If item 27 is m injury or other traumatic.		20a. Method of Disposition 1 X Burial 2 Cremation	3 Removal from Sta		Place of Dispos crematory or oth			etery,	D	ate	20c. Lo	cation - City	or To	wn, State
Page ment c		4 Donation 5 Other Speci	ify:	_	esurrecti		-		1/9/2			nton, N		
Balt Sermit Depart Injury		21. Signature of Funeral Service Lic	CV		22. N							nc 6633	3 01	d Alexandria
Physician		23a. Part I. Enter the disease, or con			. Do not enter th					MD 2073 spiratory arr		ς or heart		Approximate Interval
/Medical		failure, List only one cause on Immediate Cause (Final disease	each line. a. Multiple Injuries											Between Onset and Death
Examiner		or condition resulting in death)	Due to (or as a conse	quence o	f):			·						
	-	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conse	auence o	f\.								+	
	nine	cause. Enter Underlying Cause (Disease or injury that initiated	c.	quence o	1).									
ed asit	Exar	events resulting in death) Last	Due to (or as a consec	quence o	f):									
Box 68760, death certificate be executed ne attending physician and of or use as the burial - transit	edical Examiner		d. X AMENDED #2 0 1			107.10	010 ***						+	
60, ate be ex hysician e burial		IF FEMALE:	X AMENDED #28d			/27/2	2012,WS				23d.	Date of deli	very	
687 ertifica ding p	an/	23b. Was decedent pregnant in the past 12 months?	1 Live birth		2 Fet	al death	3 [Ectopic pr	regnancy			lonth	Day	Year
Box 6876(ne death certificate the attending phyned for use as the beath of the action of the search	Physician/M	1 Yes 2 No 9 Unknow	wn 9 Unknown	ime or ae	oth 5 Oth	ner (Spe	ecify)							
_ a 7 a		Part II. Other significant condition	s contributing to death	but not re	esulting in the u	nderlyin	g cause giv	en in Part I	I.	23e. Did to	bacco us	e contribute	to the	cause of death?
S 60 9	d b									1 Yes	2 🗸 1	No 3 F	robabl	y 4 Unknown
Vital Records yrician: The law requi	Completed									24a, Was autop				sy findings available pletion of cause of
Cecc	E O									perfor	med?	death 1		2 No
ian:	Be	25. Was case referred to medical examiner?						of Death (Ch	heck only	one)				
Physic rathis	٥	1 ✓ Yes 2 No	Hospital: 1 Inpatier		ER/Outpatient				Nursing H			æ 6 ✔ 0		
Division of Vital Records, ral or Attending Physician: The law requints after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be in by the funeral director, page 2 should be a second to the funeral director.	 	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injur (Month Day,Ye Jan 1, 2012	y ar)	28b. Time of Ir 0109 hrs	ıjury	28c. Injury	atwork? es 2. ✓ No	Su	bject driv	er of m	otorcycle	trave	ck SUV that
iSiO Atter rector by the	icat	2 Accident Investiga	ation 28e Place of Init	ury - At ho	ome, farm, stree	t, factor			obe					ront of him Route Number, City
Division pital or Atten ours after death ceral Director: filled in by the	Certification:	3 Suicide 6 Could no determin	ot be	-					Rt 2	or Town, S 210 @ Kirb		ad, Fort V	Vashir	ngton, MD
Division of Vital F To the Hospital or Attending Physician: within 24 hours after death. To the Fuoeral Director: After this certifi completely filled in by the funeral director,		(critical c	Ician: To the best of my											
To the Horwithin 24 h To the Fue	Medical	~ 🐷	ner:On the basis of exam and manner stated.	ination a	nd/or investigati				rred at the	e time, date				
	≊	29b. Signature and title of certifier	67/11.	98	0	29	oc. License O.C.M					te signed (Day, Year)
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Ba-le		 Name and address of person whe Victor Weedn MD JD 	o completed cause of de Assistant Medical			. Balti	more Str	eet, Balt	timore.	MD 2122	23			
Sta	ate	31. Date filed (Morth Avy Year) 2			. par				'					
Regist	rar		- June	- 1	· popor									

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Dorothy Irene Hankey 12:55A Medical 2012 January 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Berlin Nursing Home Berlin Worcester If Under 1 Year | If Under 24 Hrs. Social Security Number **Funeral** 7. Age (In yrs. last birthday 8. Date of Birth Birthplace (State or Foreign Country) Days 1 M 2 K F Months 6/10/1919 **Director** 220-14-6117 92 MD Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2X No Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11513 Soth Dolly Circle 21811 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 ☐ Yes 2 X No Specify. 3 XWidowed 4 Divorced Specify: Completed white Year or Dates Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) ankey, Dorothy more, Maryland 21215 of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own_Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Oval Smoot Nettie Meekins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Doug Hankey 11513 South Dolly Circle, Berlin, MD 21811 ltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ō ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or once. First State Crem. 4 ☐ Donation 5 ☐ Other (Specify) 1/9/12 Millsboro, DE 21. Signature of Funeral Service Lie 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part 1/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Die to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 XN After this certificate 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 A Residence 6 A Other (Specify) မ 2**X** No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🛚 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No injury Investigation
6 Could not be Accident within 24 hours after deat To the Funeral Director: Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Medical Examiner: To the best of my knowledge death occurred at the time cate and place, and due to the cause(s) and manner stated. 29a. Certifier Completed (Check 29b. Signature and title of certiler 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

R 135131

9715 Healthway Dr, Berlin, MD

January 9, 2012

21811

enne Lavagn

Registrar's Signatur

30. Name and address of won who completed cause of death (Item 23a) (Type, Print)

Pennie Savage, CRNP,

31. Date filed (Month, Day, Year) JAN 09 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3 Time of Death Lenora May Hilbert Physician/ 09/2012 Medical or Location of Death 4a. Facility Name (if not institution, give street and number)
Gilchrist Hospice Care 4b. City, Town, or **Towson** 4c. County of Death **Examiner** 7. Age (In yrs. last birthday) 91 Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** MD (Quntry) 213-18-1587 1 □ M 2XX **Director** 01/19/1920 28a-f show 10d. Inside City Limits notified at 10a State 10c, City, Town or Location Mottingham Director Baltimore MD 1 Yes 2 X No 10g. Citizen of What Country? United States ō 10e. Street and Number 101 Zin Code ms 23a or must be n 4529 Ambermill Road Funeral items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Examiner Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ò 1 Never Married 2 Married ş Maryland 21215-0036 within 72 hours after Specify: White If Yes, Give Year or Dates 1 Yes 2XXNo Specify: "natural", 3XXWidowed 4 □ Divorced Completed al Hygiene. I other than "natura vent, the Medical E Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Own Home Elementary/Secondary (0-12) College (1-4 or 5+) Home Maker 18, Mother's Name (First, Middle, Maiden Surname) Nina Be 17. Father's Name (First, Middle, Last) and Mental I 2 Joshua Armacost pe. t. Page 1 and 2 should be tment of Health and Men tant: If item 27 is mark∉ other traumatic 19a. Informant's Name/Relationship (Type, Print)
Richard Hilbert/Son 19b Mailing Address (Street and Number of Bural Route Number, City of Tourn State 27b Code) 4529 Ambermill Ro Nottingham, MD 27236 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 01/16/2012 Med Cure Inc. 1 🗆 Burial 2 🗆 Cremation 3 🗀 Removal from State Cumberland, RI Department of Important: If any injury or once, injury or 4 X Donation 5 ☐ Other (Specify) Minich Funeral Home M01613 Signature of Funeral Service Licens 22. Name and Address of Facility 305 N. Potonec St. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MANTAS disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Litter orderlying Cause (Disease or injury that initiated events Due to (or as a consequence of): attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ___ signed by the atter in the past 12 months? Month Year Day Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has page 2 autopsy performed? Yes 2 No Director: After this certificate 2 No 1 Yes or Attending Physician: after death. director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 Other (Specify) N 0 301 Ce 1 Yes 2 No မ 1 Inpatient 2 I ER/Outpatient 3 DOA funeral (27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No filled in by the Accident
Suicide Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral D Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signatur and title of certifier 29c. Licen 29d. Date signed (Month, Day, Year) 2011 303 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TONSON Charles AARON 60

State Registrar 31. Date filed (Month

egistrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 23a per med cert G924 2/2/12 dk

State of Maryland 7 Department of Health and Mental Hygiene For State Certificate of Death 1 Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Day Physician/ 1047AM 10,2012 anian Medical 4a. Facility Name (if not its titut Examiner eet and number) or Location of Death 4c. County of Death Stre PAH 25 PUVN If Under 24 Hrs. 9. Birtholace (State or Foreign If Under 1 Yea 8. Date of Birth 7. Age (In vrs. last birthday) 6. Sex **Funeral** Months Min (Month, Day, Year) Director 217-98-4894 1 X M 2 🗆 F 31 Jan. 5 1981 Maryland Usual Residence of Deced 28a-f shov iral", or items 23a or 28a-f sho Examiner must be notified at 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 441 Mechanic Street 21740 death v 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 X No
If Yes, Give
Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify "natural", 3 Widowed 4 Divorced Completed White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working 2 should be filed within 72 th and Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) event, the None None Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Tina Marie Neville other traumatic Jessie Scott Hasenbuhler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. e 1 and 2 s of Health 441 Mechanic Street, Hagerstown, Maryland 21740 Shawn Hasenbuhler - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Greenlawn Mem. Park 1/16/2012 Williamsport, Maryland 21. Since the of Fundal Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ TC disease or condition resulting in death) Medical or as a consequence of): **Examiner** Community-acquired pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of, Exam Change in Mental Status and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical End Stage Liver Disease the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 2 No detached been signed by the g Unknown Part II. **Other significant conditions** contr∥buting to death∣but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Unknown 1 Yes 2 No 3 Probably Completed plnous 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform within 24 hours after death.

To the Funeral Director: After this certificate I Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospita Other: 2 မှ 1 Yes Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) the funeral 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Injury at work? Certificate: 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Prin TIN-MeriTUS BARON 31. Date filed (Month State 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 Year MARY GENEVIEVE HERIDER 8:30 PM January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Herman Wilson Health Care Center Gaithersburg If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** Days Hours (Month, Day, Year) 315-10-0946 96 **Director** 1 M 2 X F 22 1915 Feb. Indiana Usual Residence of Decedent 28a-f shov must be notified at 10a. State 10c. City, Town or Location 10d, Inside City Limits Director 1 X Yes 2 No Gaithersburg MD Montgomery ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 20877 United States 301 Russell Avenue ral", or items a 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces by Black, White, etc. 1.X Never Married 2 Married 2 X No Maryland 21215-0036 1 Tes 2 No Specify: If Yes, Give Specify: White "natural", 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry and Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 0 Clerical U.S. Government other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ William George Herider Mary Reder permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gerald Gimmel / Personal Rep. 4 Professional Dr., Gaithersburg, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 1/4/2012 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crem. 21. Signature of Funer II Service Lices ee 22. Name and Address of Facility Muriel H. Barber Funeral Home P.O. Box 5038, Laytonsville, Maryland 20882 23a. Par/1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Cerebrovascular Disease Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): sician and burial-transit Exami law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) ng physician as the burial Physician/Medical Box 68760 attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☑ No Por Day Month Year Pregnant at time of death ed by the a detached i 9 Unknown 9 Unknown Division of Vital Records, P.O. signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s Jas autopsy performed? Yes 2 No or Attending Physician: The 1 Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 🗹 No Hospital: Other: 1 Yes ပ 4 Nursing Home 5 Residence 6 Other (Specify) s after dea...
ral Director: After u...
- by the funeral dr 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Hospital 24 hours a Funeral L Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier npletely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2.

To the F
complet Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) D 20148 January 3, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

/ State Registrar

5

Steven H. Dolinsky, M.D.

31. Date filed (Month Pax)

32. Registrar's Signature

REERIA.

911 Russell Ave., Gaithersburg, MD

20879

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 1 1 Day 2012 7:15A M Jan. Carol Ann Hughes- Matchem Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert Prince Frederick Calvert Hospice If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Birtnpi Social Security Number **Funeral** Months Hours Min. (Month, Pay, Year) /30/1940 1 M 2 K 6 **Director** 32 0591 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1 X Yes 2 No Hollywood Mary's st. MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral within 72 hours after death with USA 20636 41775 Sheiloh Way or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? Examiner Black, White, etc. 1 Never Married 2 Married þ Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 😾 No Specify. . Page 1 and 2 should be filed within 72 hours afticment of Health and Mental Hygiene.
tant: If item 27 is marked other than "natural",
jury or other traumatic event, the Medical Exal Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) DOD Program Analyst 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Rosa Manns Blakley Hughes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 41775 Sheiloh Way Hollywood, MD 20636 Alfred D. Matchem/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 XBurial 2 Cremation 3 Removal from State Department of Important: If any injury or once. St. Johns Cemetery 1/16/2012 Hollywood, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Briscoe-Tonic Funeral Home 21. Signature of Funeral Service Licenses 38576 Brett Way Mechanicsville,MD 20659 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ UYS I mon! disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of, as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) the attending physiciar Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial completed filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Day Year Pregnant Pregnant at time of death 1 ☐ Yes ∠ ı g ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 1 Tes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury 28b. Time of 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural (Month, Day, Year) injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State

29a. Certifier

Gurdee

29b. Signature and title of certifier

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mhabraud

Registrar

23415

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D 5068

29d. Date signed (Month. Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ JANUARY 05:13 AM 2012 GLORIA DEBRA HODGSON Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** UNION HOSPITAL OF CECIL COUNTY ELKTON CECIL Birthplace (State or Foreign Country) If Under 24 Hrs 8. Date of Birth (Month, Day, Year If Under 1 Year Social Security Number 6. Sex '. Age (In yrs. last birthday) Funeral Days Hours Min. Months 1 M 2 X F NEW JERSEY 1941 Director 140-32-5275 70 4. Usual Residence of Decedent 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10b. County 10a, State should be filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2 🛣 No MARYLAND ELKTON CECIL 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral 21921 UNITED STATES 125 EGG HILL LANE Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S 11. Marital Status Black, White, etc. Armed Forces?
1 ☐ Yes 2XXNo 1 Never Married 2XXX Married ≥ Baltimore, Maryland 21215-0036 WHITE 1 Yes 2XXNo Specify. If Yes, Give "natural", 3 - Widowed 4 - Divorced Completed Year or Dates. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) CORNELIA PEDZINSKI BRONISLAUS BRZOZOWSKI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 125 EGG HILL LANE, ELKTON, MARYLAND permit. Page 1 and 2 JOHN D. HODGSON / 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of JANUARY 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) NORTHE TEAST CEMETERY 12, 2012 NORTH EAST, MARYLAND 22. Name and Address of Facility CROUCH FUNERAL HOME, P.A. 21. Signature of 127 SOUTH MAIN STREET, NORTH EAST, MARYLAND 21901 polications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between 23a. Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause on Onset and Death Immediate Cause (Final Priysician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine as the burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE for use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live Birth 2 - Fetal death in the past 12 months? Month Dav Year Pregnant at time of death certificate has been signed by the rector, page 2 should be detached g 🗌 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗌 No Yes 26. Place of Death (Check only one) director, To Be 25. Was case referred to medica examiner? Other: 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this s after death.

I Director: After this ed in by the funeral d 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury 28d. Describe how injury occurred 27. Manner of Death Certificate: (Month, Day, Year) injury Natural 5 Pending Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours after
To the Funeral Dire Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year)

State Registrar address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are 1 equiple State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2< AM Charles Willard Harvey Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Western MD Regional Medical Center **Cumberland** Allegany If Under 1 Year **Funeral** 7. Age (In vrs. last birthday) If Under 24 Hrs 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Days Director 1 M M 2 🗆 F 217-10-7031 Usual Residence of De 96 March 19, 1915 Maryland or 28a-f show notified at 10a State 10b. Count 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 X Yes 2 No Maryland Allegany Frostburg 10e. Street and Numbe 0 10f. Zip Code ms 23a or must be n 10g. Citizen of What Country? 324 Braddock Street U.S.A 21532items 2 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ ō 1 Never Married 2 Married Yes f Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No "natural" Completed 3 K Widowed 4 Divorced Year or Dates. WWT White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. other than ' Elementary/Secondary (0-12) College (1-4 or 5+) the State Government Contract Writer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H ည Charles S. Harvey Maggie McKenzie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health em 27 21046-Leland Harvey brother Maryland 10233 Donleigh Drive Columbia 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Page 1 Burial 2 Cremation 3 Removal from State 5 Department of Important: If any injury or 4 Donation 5 Other (Specify) Frostburg Memorial Park 1/18/2012 Frostburg Maryland Signature of Funeral Service Licenset 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Myocardial Medical resulting in death) **Examiner** idi omyopa Sequentially list conditions, if any, leading to inmediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events burial-trar Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Atrial Fibrillation nomic 68760 as the F FEMALE asn yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box Cother (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy certificate Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 🗶 No Be 26. Place of Death (Check only one) Other: မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this Certificate: Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 Natural 5 Pending iniury work? Accident Suicide Investigation 2 🗌 No 24 hours after deatl Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one within To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) CRNP-AC 15/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Janette M. Clark, 952 Seton Drive, Cumberland, MD 21502 State 32. Registrar's Signature Registrar

12-00341	Please Type or Print in Black Indelible Ink. Ensure All Co	pies Are Legible.
Sharon A. Hostetler	• •	
	1- For State Registrar Certificate of Death	Reg. No.
Physician/	Decedent's Name (First, Middle,Last)	2. Date of Death Month Day Year 2. Date of Death
Medical Examiner		January 11, 2012 2245 hrs
	4a. Facility Name (if not institution, give street and number) Anne Arundel Medical Center 4b. City, Town, or Location of Annapolis	Death 4c. County of Death Anne Arundel
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 1	
Director	217-72-7908 1 M 2 F 53 Yrs. Months Days Hours	May 29, 1958 Foreign Country) Washington
	Usual Residence of Decedent	ridy 25, 1550 sammwasimigton
, and	10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
and nce.	Maryland Anne Arundel Lothian	1 Yes 2 X No
the Maryland n or 28a-f sh iffied at once Director	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
h the 33 or lotifie	30 Daniel Court 20711	USA
er death with t , or item: 23s r must be not Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin 14. Was Decedent of Hispanic Origin 15. Married Forces? 17. Married Porces? 18. Was Decedent of Hispanic Origin 19. Married Proces?	
er dea	1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:	specify: White
urs after	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give king the complete of t	
5-0036 ed within 72 hours dylygiene. other than "natu the Medical Exan Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT us	
nthin and the control of the control	12th Office Manager	Stee1
15-0 filed v al Hygi of other fr. the C		Name (First, Middle, Maiden Surname)
21215-0036 uld be filed within 7 Mental Hygiene. e cerent, the Median		e Elizabeth Mumford or Rural Route Number, City or Town, State, Zip Code)
ID 21 Should and Me 77 is ma To	Pylesville, MD 21132	
9, N and 2 lealth item 2	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date 20c, Location - City or Town, State
nt of H	1 Burial 2 X Cremation 3 Removal from State crematory or other place) 4 Departion 5 Other Specify: Kalas Crematory	1/18/12 Edgewater, MD
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	4 Donation 3 Other Specify.	George P. Kalas Funeral Home
In the Dept.		sland Rd. Edgewater, MD 21037
Physician	23s. Parf I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card failure. List only one cause on each line.	tiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and
/Medical £xaminer	Immediate Cause (Final disease a. Atherosclerotic Cardiovascular Dis	5 4
N .	or condition resulting in death) Due to (or as a consequence of):	
9	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
kaminer	cause. Enter Underlying Cause (Disease or injury that initiated	
ति । 🖫 ह	events resulting in death) Last Due to (or as a consequence of):	
O. Box 68760, that the death certificate be executed need by the attending physician and detached for use as the burial - transit by Physician/Medical E)	d. ☐ AMENDED 23a,27,per me,g924 2-15-12 s	m I
60, te be hysici buria	IF FEMALE: 23c. If yes, outcome of pregnancy	23d. Date of delivery
587 ertifice ling p	23b. Was decedent pregnant in the past 12 months?	
OX (sath co	1 Yes 2 ✓ No 9 Unknown Pregnant at time of death 5 Other (Specify)	
D. B trithe d by the ached	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part	23e. Did tobacco use contribute to the cause of death?
P.C es that igned be deta		1 Yes 2 V No 3 Probably 4 Unknown
rds, requir been s bould I		24a. Was an 24b. Were autopsy findings available
Records, The law requires ficate has been sign, page 2 should be Completed	- <u>-</u> -	autopsy prior to completion of cause of death?
Vital Records, P.O. ysician: The law requires that the list centificate has been signed by director, page 2 should be detach o Be Completed by P.	25. Was case referred to medical 26.Place of Death (C	1 ✓ Yes 2 No 1 ✓ Yes 2 No neck only one)
Division of Vital Records, P.O. Box 68760, ral or Attending Physician: The law requires that the death certificate be as after death. The this certificate has been signed by the attending physiciled in by the funeral director, page 2 should be detached for use as the buriterification: To Be Completed by Physician/Med	examiner?	lursing Home 5 Residence 6 Other:
ing Ph After ti uneral	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred
Division of ' tial or Attending Ph Ins all birectors the lled in by the funeral lettification: T	1 Natural 5 Pending 2 Accident Investigation (Month, Day, Year) 1 Yes 2 N	0
Divisior al or Attend as after death Director: ed in by the	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City or Town, State)
	4 Homicide determined (Specify)	

To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the t

rents resulting in death) Last	, ,			1	
d. UNPENDED	AMENDED 23a,27,per me,g924 2-15-12 sm				
FEMALE: D. Was decedent pregnant in the past 12 months? Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown		3d. Date of delive Month	ery Day	Year
art II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.		o use contribute t	_	f death? Unknown
		24a, Was an autopsy		autopsy finding completion of	

			performed? 1 ✓ Yes 2 No	death? 1 🗸 Yes	2 No
25. Was case referred to medical		26.Place of Death (Check	only one)		
examiner? 1 ✔ Yes 2 No	Hospital: 1 ✓ Inpatient 2 ER/Outpatient 3	DOA Other Nursin	ng Home 5 Residenc	e 6 Other:	_
27. Manner of Death 1 X Natural 5 Pending 2 Accident Investiga		28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury	occurred	
3 Suicide 6 Could no determine	at be 28e. Place of Injury - At home, farm, street, fac	ory, office building, etc.	28f. Location (Street and or Town, State)	Number or Rural Rou	ute Number, Cit

29a. Certifie (Check only	1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state
	2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the

one) 2 Medical Examiner: On the basis of examination and/	or investigation, in my opinion, death occurred at the	time, date and place, and due to the cause(s)
29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
((as fully and)	O.C.M.E.	January 14, 2012

30. Name and address of person who completed cause of death (Item 23a)

OCME

900 W. Baltimore Street, Baltimore, MD 21223 Laron Locke MD. Assistant Medical Examiner

State Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ JAN. THELMA LOUISE HUDSON 2012 10:26 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CIVISTA MEDICAL CENTER LA PLATA CHARLES Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 408-26-8272 1 🗆 M 2 😾 F **Director** 89 8-11-1922 TN. Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director MD. CHARLES 1 Yes 2 No WALDORF 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? o must be 23a 70 VILLAGE LANE 20602 U.S.A. or items Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 😾 No Specify Specify: WHITE "natural", 3 ₩ Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME 12th and Mental Hygier is marked other t other traumatic event, Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) FLOYD DONALD MCPHERSON EVIE GREEN NEAL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st.
Department of Health an
Important: If Item 27 is 1 WALDORF, MD. 20601 CYGNET DRIVE JOYCE CAMPBELL-DAUGHTER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ▼ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) woodlawn cemetery 1-14-12 NASHVILLE, TN. 21. Signature of Juneral Service Lice 22 Jame and Address of Facility M00479 RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 23a. Part 1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on each Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 the as attending IF FEMALE. 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 month for Month Dav Year 9 Unknown 9 Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed to þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed or Attending Physician: The law this certificate 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 Inpatient 2 KER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death I Director: After to ad in by the funers 28b. Time of 28c. Injury at Certificate: Natural 5 Pending 1 Yes 2 No hours after death Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie

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DHMH 17 Rev 06-2011

Registrar

State

cause of death (Item 23a) (Type, Print

2 4 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ARRET Goodwi Mennonite RANTSVILLE 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 75-20-7493 Months Hours Min. (Month, Day, Year, **Director** Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If tiem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Somerse Meversdale 1 X Yes 2 ☐ No 10e. Street and Numbe 10g. Citizen of What Country? Funeral KRAUSE TRAILER PARK 134 5552 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?.

1 Yes 2 No 14. Race - American Indian Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Samuel မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or RONAID Hostetler lisbur 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 🗆 Burial 2 2 Cremation 3 🗆 Removal from State -21-12 ountryside 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses M. RAYLECKEMBY Funeral Home 22. Name and Address of Facility 10094 Meyersdale 203 NORTH ST 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line. Interval Between Opset and Death Immediate Cause (Final Physician disease or condition resulting in death) seasin VPOLV Medical Due to (or a a consequence of): Examiner Sequentially list conditions. Examine cause. Enter Underlying Cause (Disease or linjury Due to for as a norterior result attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) signed by the a P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 Probably 4 Unknown within 24 hours ar er decth.

To the Funeral Director After this certificate has been sis completed filled in by the funeral director, page 2 should by 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform 1 Yes 2 No Yes Division of Vital Be 25. Was case referred to medical 26. Place of Death Check only one) examiner? 2 X No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 A Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

who completed cause of death (Item 23a) (Type, Print)

DOO 31179

18

201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 19a per in 8924 2-6-12 vt.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death ^{Day} 10 JANUARY Physician/ 2012 12:59 p^M MATTIE JANE HODGE Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Cecil Warwick Smith Creek Assisted Living If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Month, Day, West Virginia 1 □ M 2🐙 ⁴1923 Director 88 233-58-4847 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 X No MD Cecil Elkton 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number Funeral 21921 U.S.A. 386 Muddy Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No Black, White, etc Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates 3 Ulidowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Materials & Technology Elementary/Seconday (0-12) College (1-4 or 5+) Assembly Lineworker Manufacturer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Belva Effie Collins James Henry Workman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Hodge 386 Muddy Lane Elkton, MD. 21921 Robert (husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Beckley, W. Virginia Blue Ridge Cemetery 1/14/12 4 Donation 5 Other (Specify) ^{22. Name and Address of Facility}
Galena Funeral Home of Stephen L.
118 West Cross St. Galena, MD. 21 Huneral Servi M00510 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heaft failure. List only one cause on each line.

Immediate Cause (Final disease or condition Approximate Interval Between Onser and Death Demontes Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 1 ☐ Yes ∠ E g ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 nknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No Yes 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Division of Vital Be Assisted Hospital Other:
4
Nursing Home 5
Residence 6
Other (Spe 2 No 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 잍 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: iniury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and tity of certifier 29d. Date signed (Month, Day, Year) 29c. License number D0023322 1.10.2012 acholes 8 NO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S.S SACHIDEV 126 A. E. H. C. Elp 6n MD 21921 E High 126 A, 31. Date filed (Month, Day Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3:20рм Bertha Jalickee Januaru Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Rockville Casey House Social Security Number If Under 1 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral Days Hours (Month, Day, Year) Director 579-22-9483 100 1 🗆 M 2 🗓 F 11/23/1911 Washington show 10c. City, Town or Location 10d. Inside City Limits at 10a. State 10b. County Director ms 23a or 28a-f s must be notified 1 Yes 2 X No Bethesda Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2617 East-West Highway 20815 U.S.A. ral", or items 2 Examiner mus death \ 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. Completed by 1 Never Married 2 Married 3altimore, Maryland 21215-0036 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No Specify Specify White 3 X Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) Collegé (1-4 or 5+) Healthcare Registered Nurse 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) d Mental | ပ Elizabeth Schastnaya Alexander Dubatsku 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 7608 Clarendon Road, Bethesda, Maryland 20814 John B. Jalickee - Son 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Department of F. Important: If ite any injury or other Page 1 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Crematory 01/11/2012 | Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, monutolk 11800 New Hampshire Ave., Silver Spring, MD 20904 MD1524 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Congestive Heart Failure disease or condition Medical resulting in death) Examiner Aortic Stenosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) transit Cause (Disease or injury that initiated events and Due to (or as a consequence of) resulting in death) Last the buria attending physician To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the bur Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🕱 No
9 ☐ Unknown 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown Dav Year Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Aortic Atresia 1 Yes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Chronic Obstructive Pulmonary Disease 24a. Was an autopsy performed 1 Yes 2 No 1 Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 X No ٩ 4 Nursing Home 5 Residence 6 X Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at 1 X Natural 5 Pending 1 Yes 2 No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to only one) 29b. Signato 29d. Date signed (Month, Day, Year) R143201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6001 Muncaster Mill Road, Rockville, Maryland 20850 Debrah Miller. CRNP,

Registrar

Date filed (Month, Day, Year

JAN 06

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ $\overset{\text{Month}}{0}$ 20T2 James William Johnson 11:25 a^M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Fort Washington Prince Georges Fort Washington Medical Center Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 XM 2 F Months Days Hours Min 127/27ay 1949 Director 217-60-7919 62 DC Usual Residence of Decedent or 28a-f show th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MDCalvert 1 Yes 2 X No Prince Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 1826 Lottie Fowler Road 20678 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. 1 X Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Mail Room/Printshop International Union Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Thomas R. Johnson, Sr. Margaret Breslin and 2 should by Health and Metern 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Regina M. Reese / Sister 45620 Nicholas Court, Great Mills, MD 20634 injury or other item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔲 Burial 2 🕱 Cremation 3 🗀 Removal from State 4 Donation 5 Other (Specify) Lee Crematory 01/11/2012 Clinton, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 8200 Jennifer Lane, Owings, MD 20736 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cardiac Arrthymia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Cirrhosis of the Liver Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of death certificate be executed resulting in death) Last Due to (or as a consequence of) bunial-Physician/Medical Box 68760 the ending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy atter for u in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed | I be det 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ♣ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h performed 2 🗌 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☑ No Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Matural 5 Pending n 24 hours after death.

e Funeral Director: Afte bleted filled in by the fur Accident
Suicide 1 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined completed filled in City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only on Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signat re and title of certifi KM Name and address of person who completed cause of death (Item 23a) (Type, Print) Clinton 7700

DHMH 17 Rev 7/2009

State

Registrar

Date filed (Month.

Day, Year

10

Division of Vital

32. Registrar's Signatu

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			For State Registrar			arylan		artment <i>tificate</i>		lealth and N Death	Mental Hy	giene Reg. No	201	2 0	1718	
	Physicia		1. Decedent's Name NELLIE ES		^{st)} ECKWITH JO	HNSON	I		,		2. Date of De Month 01/02		ay Year		of Death	
-	Medie Examir	Examiner 4a. Facility Name (if not institution, give street and number) Manor Care Health Services								Location of Death	4c. County of					
	Funeval		5. Social Security No			e (In vrs. la	ist birthday)	Beth If Under		a If Under 24 Hrs.	8. Date of Bi		ontgame:		or Foreign	
	Funeral Director		215-76-40 Usual Residence of	015	□ M 2 XF 10		Yrs.		Days	Hours Min.	(Month, Di 12/26/	irith 9. Birthplace (State or Foreign Country) 1906 MD				
	fand show dat	tor	10a. State	10b. County		10c. City	, Town or Loc	cation						10d. Inside	•	
	Mary 28a-1	Director	MD	Montgome	ery	Bet	hesda	1							es 2 No	
	with the	Funeral [10e. Street and Nun		.vd.		10f. Zip Code 20817						10g. Citizen of What Country? USA			
	death items		11. Marital Status		12. Was Decedent : Armed Forces?			Vas Decede f Yes, specif	ent of His fy Cubar	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		14. Race - Ame Black, Whit			
9036	urs after ural", or I Exami	ted by	1 ∐ Never Marri 3 🛣 Widowed	ied 2 Married 4 Divorced	1 ☐ Yes 2 XI If Yes, Give Year or Dates.	No	1	☐ Yes 2	X No	Specify:			Specify: Bla			
15-(72 hou n "nat /e dica	Completed		15. Decedent's E ecify only highest gr	ade completed)		(Give h	lent's Usual kind of work O NOT use i	done d	ation uring most of work	ing	16b. k	(ind of Business	Industry		
212	within giene. er tha , the N	Cor	Elementary/Second	onday (0-12)	College (1-4 or s	5+)	House		ictii day			Ног	me			
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be	17. Father's Name (F John Beck							18. Mother's Nam Maria Ta		, Maiden	Surname)			
Man	2 shoul th and I 27 is ma trauma		19a. Informant's Na		Type, Print) .an/daughte	or				nd Number or Rur treet, NI						
Ţe,	1 and f Heal item 2		20a. Method of Disp	position		20b. P	lace of Dispos	sition (Name	e of		Date		ocation - City or			
imo	Page ment o ant: If ury or			☐ Cremation 3 ☐ 5 ☐ Other (Speci	Removal from State (fy)		emetery, crem oury UM	-			9/2012	Ge:	mantow	n, MD		
Balt	permit. Departi Import any inj		21. Signatur Fur	neral Service Lin	i La	ul.	- N. C			s of Facility Sno				20050		
			23a. Part 1. Enter t	he disease, or com	plications that caused	d the death				nington S			те, мр.	Approxim		
	h, sician/	3 5	Immediate Cause (disease or conditio	Final	Athero		otic h	eart	dise	ease				Interval B Onset and		
-	Medical Examiner		resulting in death)		Due to (or as		ence of):									
		iner	Sequentially list conditions, if any heading to immediate cause. Enter Underlying													
,	be executed ician and burlal-transit	Examiner	Cause (Disease or i that initiated events resulting in death) L	linjury s	c. Histor			alhem	ator	ma old						
	e be ex ysician e burla	ᡖ	,		I d										-	
9879	Certificate by tending physic ruse as the b	/Med	IF FEMALE:		ODe Muse enterms	-6						1				
SC	death Ce ne attend ed for us	sician	23b. Was decedent in the past 12 r	months? X No	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Feta	∣death 3 🗌	Ectopic produced Other (spe		у			23d. Date of de Month	elivery Day	Year	
P.O. B9	af the ed by th detache	/ Phy	9 Unknown Part II. Other signifi		ontributing to death b	out not resu	ulting in the u	nderlying ca	ause giv	en in Part I.	23e. Did 1	tobacco	use contribute to	the cause of	death?	
So.	quires ti en signe ould be	ted by									1 🗆	Yes 2	ĽXNo 3□F	robably 4	Unknown	
Recor	To the Hospital or Attending Physician: The law requires that the defit Cert within 24 hours atter death. To the Funcaral Director. After this certificate has been signed by the attendin completed filled in by the funeral director, page 2 should be detached for use	Completed by Physician/Medic									24a. Was auto perfo 1 \(\sum \) Yes	DSV	prior to	topsy findings completion of s 2 \(\sime\) No	available cause of	
व्य	cian: ertifica ector, I	Be	25. Was case referre		Hospital:				1	ace of Death (Chec						
<u>></u> ∡	Phýsi this c ral dire	유	1 Yes 2 2 27. Manner of Death	A NO	1 Inpati		ER/Outpatien 28b. Time of		Othe c. Injury	4X Nursing H	ome 5 Resi		Other (Spec	cify)		
80,00	ending eath. or: After he fune	Certificate:	1 X Natural 2 ☐ Accident	5 Pending Investigation	(Month, Da		injury	М 201	work'	Yes 2 □ No	200. Describe	now injur	y occurred			
Divisi	fal or Att		3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place of Injubuilding, etc			et, factory,	office		28f. Location (City or To		d Number or Ru	ıral Route Nun	nber,	
(he Hospi in 24 hou he Funer: pleted fill	Medical	(Check 2	Medical Exam	sician: To the best of iner: On the basis of e se Practioner: To the	xamination	and/or invest	igation, in m	y opinio	n, death occurred a	t the time, date	and place	, and due to the	cause(s) and n	nanner stated.	
	2 m 2 m 2		29b. Signature and t	title of dertilier	7//10	1				number			te signed (Mont	h, Day, Year)		
	•		30. Name and addre	eas of person who	completed cause of d	leath (Item	23a) (Type, P		369.	<u>.</u>		01/	04/2012	-		
			Ajay Redo		200 Tower				.0,	Rockville	e, MD 2	0852		 .	<u> </u>	
	Sta Registra			N 0 5 201	2 Registra	ars Signat	fer for	Med.								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] | 2 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month SHARMETTA ANN JACKSON 8, **JANUARY** 2012 6:10 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST HOSPICE CENTER TOWSON BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Hours Days 219-74-9719 Director 1 □ M 2 🔀 F 53 JULY 25, 1958 MARYLAND Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits notified at Director MARYLAND 1 X Yes 2 No HARFORD BEL AIR 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ò ms 23a or Funeral 1327 AMYCLAE PLACE 21014 UNITED STATES items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner Armed Forces? Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify Specify: BLACK Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) ADMINISTRATIVE ASSISTANT COUNTY GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname မ CHARLES IVIN MITCHELL BETTY ANN PRESBURY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CORDELL JACKSON / HUSBAND 1327 AMYCLAE PLACE, BEL AIR, MARYLAND 21014 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State cemetery, crematory or other place) ATLANTIC CREMATORY 1/12/12 GLEN BURNIE, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee LISA SCOTT FUNERAL HOME, 552 LEWIS STREET, HAVRE MD 21078 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician. DNOST cancer disease or condition West S Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) Examine Due to (or as a consequence of) the burial-transi Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): aftending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be to thours after death. Funeral Director: After this certificate has been signed by the aftending physicis. P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? Month Day Year Pregnant at time of death been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Records, No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes Division of Vital Be (filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence ျှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Other (Specify) 7. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basic of examination and/or impation in a stated Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the I 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) and title of certifie 29b. Signat 29d. Date signed (Month, Day, Year) 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Currles 57 + NOUS 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible 12, WS AMEND TITEM#23a, e, perrhits, #18,20b-c, perrhits, 924,271072012, WS State of Maryland / Department of Health and Mental Hygiene 2012 State Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 10:45 A M Ritha Jean-Michel January Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery 1903 Lyttonsville Road Silver Spring 5. Social Security Number If Under Birthplace (State or Foreign Country) Age (In yrs. last birthday, 8. Date of Birth **Funeral** Months Hours (Month, Day, Year) Director 1 □ M 2 🕱 577-62-2865 84 Yrs Sept 1, 1927 Haiti Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director 1 Tes 2 X No Maryland Montgomery Silver Spring 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? Funeral 20910 Haiti 1903 Lyttonsville Road within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item edical Examiner n 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. ģ 1 Never Married 2 X Married Maryland 21215-0036 **Black** 1 ☐ Yes 2 X No Specify: Specify Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Registered Nurse **Health Services** of Health and Mental Hygie If item 27 is marked other other traumatic event, the Be 17. Father's Name (First, Middle, Last) 8. Mother's Name (First, Middle Maiden Surname)
Therese Maximilien Belot
Therese Belot ٩ should be Othoniel Dorsainille 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 1903 Lyttonsville Road, Silver Spring, Maryland 20910 Marc Jean-Michel, Srasspouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Bal cimeter crematory or the place on Pk. 12 Ft. Lincoln Crematory 1/11/2012 1 🗌 Burial 2 ី Cremation 3 🗌 Removal from State Baltimore 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland neral Service Licensee 22. Name and Address of Facility Simple Tribute 21. Signature MO1102 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line.
lediate Cause (Final asse or condition as or condition as the cause of the c Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Examine Due to jor as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): burial attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death Month Day Year signed by the Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 No 3 ☐ Probably 4 tonknown Neurogenic Bladder Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform within 24 hours after death.

To the Funeral Director: After this certificate 2 X No 2 No 1 Yes Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 X No 욘 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d, Describe how injury occurred X Natural 5 Pending injury work? 1 Yes 2 No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only one) Certifying Nurse Practitioner occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 00 29c. License number 29d. Date signed (Month, Day, Year) 53235 1/4/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 13635 Baltimore Avenue, Laurel, Maryland 20707 Darryl Hill, M.D. 31. Date filed (Month, Day, Year) Registrar's Signature State **JAN 1** 0 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amended #23a(a), n1sper phy., 01/12/12, State of Maryland / Department of Health and Mental Hygiene Allegany Co. **1 -** State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Marie Ann Johnson January 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Allegany Health Nursing & Rehab Ctr Cumberland Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign 1 M 2 TF Months Days Hours 199-38-9809 67 Director 07/05/1944 Pennsylvania Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.
27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director MD Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 220 Somerville Avenue, Apt 714 21502 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black White etc. 1 Never Married 2 Married Completed by 1 Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: 3 🗓 Widowed 4 🗆 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Henry Thomas East Anna Julia Grodolsky permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Amy Cuono / Daughter 2389 Ridge Road, Chincoteague, VA Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cumberland Crematory 01/11/2012 Cumberland, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD Part 1. Let the disector, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final 2011 Physician/ STAGE disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or iinjury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician a for use as the bunal-Physician/Medical that the death certificate be 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Month signed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, icate has been sig ; page 2 should b 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No To the Hospital or Attending Physician: 7 within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director; I of Vital æ 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work?
1 Yes 28d. Describe how injury occurred 1: Natural 5 Pending injury Division Accident 2 🗌 No ☐ Acciden☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one 29b. Signature and title of certifier 29c License number 29d. Date signed (Month, Day, Year) (DTG

3. Time of Death

10d. Inside City Limits

White

Approximate Interval Between Onset and Death

Day

21502

Year

1 X Yes 2 No

Allegany

1950 P M

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature JAN 12 2012 arkad

30. Name and address of person who completed cause of death (Iten) 23a) (Type, Print)
Robustiano J. Barrera, M.D., 200 Glenn Street, Cumberland, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month was 0809M Physician/ 20/2 II Donald Jordan L. Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** <u>Prince Georges</u> Accokeek 13210 Suntum Court Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Social Security Numbe **Funeral** (Month, Day, Year) Days Hours 1 XM 2 - F SC 1984 Director 13. 250-63-0188 Usual Residence of Deceden 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10a. State .1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene.

fitem 27 is marked other than "natural", or items 23a or 28a-f sho of them 27 is marked other than "natural", or items 25a or 28a-f sho of the traumatic event, the Medical Examiner must be notified at other traumatic event, the Medical Examiner must be notified at Director 1 XYes 2 No <u>Accokeek</u> MD PG 10g. Citizen of What Country? 10e. Street and Number Funeral United States 20607 13210 Suntum Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates. Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Military <u>First Lieutenant</u> Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Walker Elmaria Donald L. Jordan Sr age 1 and 2 should but of Health and Mer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3210 S CCOKEE Suntum ek MD C98567 Donald L. Jordan Sr/father 20b. Place of Disposition (Name of Baltimore, 20c. Location - City or Town, State 20a, Method of Disposition 1/12/12 cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State ò Department or Important: If any injury or Cheltenham, MD Cemetery 4 Donation 5 Other (Specify) Md. Veterans 22. Name and Address of Facility Hodges & Edwards F.H. Signature of Funeral Service Licenses Suitland, MD. 20746 3910 Silver Hill Rd., 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, rock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition AS KiATias phy Physician/ Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Box 68760 as IF FFMALE If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____
9 ☐ Unknown nse 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown for s been signed by the sahould be detached P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? performed' 2 No Yes 2 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? 4 Nursing Home 5 Residence 6 Other (Spec 1 Inpatient 2 ER/Outpatient 3 DOA ျှ this 28d. Describe how injury occurred 177 28a. Date of injury (Month, Day, 28b. Time of 27. Manner of Death 28c. Injury at Certificate: injury 50% After work? homs el ☐ Natural 5 Pending at home JANUAR, 2012 Accident Investigation within 24 hours after death To the Funeral Director. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 13 2/0 Sew fr Court, Accokeek, MAY 6 Could not be 28e. Place of njury - At home, farm, street, factory, office building, etc. (Specify) Guicide in by 1 4 Homicide determined home Accokeek 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 3+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death 01/05/5015 Physician/ Josephine Jenkins 17:38 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Fort Washington Hospital Prince Georges Ft. Washington If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday **Funeral** 1 □ M 2 🛛 F Hours Director 105-22-6380 83 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic event. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Prince Georges Temple Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4108 Norcross St. 20748 AZU Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, ģ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 **X** No 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 ☐ Divorced Completed Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Garment Manufacturer Factory Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Anna Mae Roberts Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ralph Williams / son 4108 Norcross St., Temple Hills, MD 20748 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 01/04/2012 Beltsville, MD 22. Name and Address of Facility Strickland Funeral Services 21. Signa ure f Funeral S 6500 Allentown Rd⋅₁ Camp Springs₁ MD 20748 23a. Pat. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Occur Wal disease or condition resulting in death) Medical Due to (or as a conseq Examiner atherosi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE . If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month 1 Yes 2 g Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Pulmonas Disease 1 Yes 2 4 No 3 Probably 4 Unknown Completed Premong 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 Npatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at work?
1 Yes 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 2 🗌 No ☐ Accident ☐ Suicide Investigation 6 🗌 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Addical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature title of certifier 29d. Date signed (Month, Day, Year) MD

State Registrar

RICHARD

31. Date filed (Month, Day, Year)

JAN 1 1 2012

PALMER

1328 Jouthern avenue SE Sunto 310

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

D0055120

3rd, 2012

Wanhington DC

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1325 Month Physician/ 2012 Sr James Orville Raymond Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Allegany Cumberland WMHS-RMC If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Country) WV **Funeral** Aug 3, 1941 Days Hours Min 234-64-3455
Usual Residence of Decedent **Director** 1 □**X**M 2 □ F 70 Yrs. 28a-f shov 10d. Inside City Limits should be filed within 72 hours after death with the Maryland and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location Director or items 23a or 28a-f s miner must be notified MD Allegany Cumberland 1 XYes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21502 USA 730 Furnace Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian 11. Marital Status Examiner Armed Forces? Black, White, etc 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 ier than "natural", c , the Medical Exam 1 Ves 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed with Department of Health and Mental Hygien Important: If item 27 is marked other thany injury or other traumatic event, the once. collision repairman Stan's Auto Body Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Carrie L. Houdershell Ray O. James 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) MD 21502 LaVale Melinda Wariner daughteh 1127 Braddock Road 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Xemation 3 ☐ Removal from State 1/12/2012 Scarpelli Funeral Home, P.A. MD Cresaptown Donation 5 - Other (Specify) 22. Name and Address of Eacility
Scarpelli Funeral Home, PA f Funeral Servi Licensee ignature 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final rudile Physician/ 50016 disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine Due to (or as a consequence of) draw, reading to immediate cause. Enter Underlying Cause (Disease or injury the attending physician and thed for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown in the past 12 months? be detached for Month Dav Year 2 No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has performed' 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director After the After the Funeral Director After the Funeral Director After the After the Funeral Director After the After the Funeral Director After the Aft funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes 2 - No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 1 Matural 5 Pending work 1 Tyes 2 🗌 No Accident Suicide Investigation Could not be 28e. Place of Injury At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Pragfitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 8, 2012 Janvan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 924 vikramaditya

DHMH 17 Rev 06-2011

State

Registrar

JAN 2 3 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 20 Î2 Jeanne Kemeys 4:40 A M N. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Sandy Spring Brooke Grove Rehab and Nursing If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours (Month, Day, Year) **Director** 579-38-9189 1 🗆 M 2 🕱 F June 12 1925 Washington, D.C Usual Residence of Decedent 28a-f show 10a. State 10d. Inside City Limits with the Maryland r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City. Town or Location Director 1 Yes 2 No Montgomery Silver Spring MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3210 Norbeck Road, 20906 Apt. 313 United States death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. L 1215-0036

L 1215-0036

Department of Health and Mental Hygiene.
Important: If item 27 is marked other than any any injury or other trainments. þ 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: White If Yes, Give Year or Dates Completed 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Own Home 12 0 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles Newhall Ruth Edmonston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 24104 Preakness Dr., Damascus, Maryland 20872 Walter S. Kemeys / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 🗹 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Metropolitan Crem. 1/3/2012 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Muriel H. Barber Funeral Home 20882 0. Box 5038, Laytonsville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Peritoneal Carcinomatosis weeks disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physicis Records, P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Fctopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day 4 Pregnant 9 Unknown 5 Other (specify) Pregnant at time of death 1 Yes 2 9 Unknown been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Diabetes, Hypertension, TIA, CAD, 2 ☐ No 3 ☐ Probably 4 🛎 Unknown 1 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? Hypothyroid, Cholesterol 24a. Was an cate has page 2 s autopsy performe Yes 2 No 1 Yes 2 No Division of Vital 24 hours after death.

Funeral Director: After this certific etely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 🖾 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) Hospital: 1 ☐ Yes 2 € No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5 \square Pending 1 🗷 Natural Investigation Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the Ewithin 2 To the F 3 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9 10301 Georgia Ave., #209, Silver Spring, MD Anuradha Arun, M.D.

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

32. Rigistrar's Signature

		For State of Maryland		artment of He ctificate of D			2.0	12	01726
		Registrar 1. Decedent's Name (First, Middle, Last)	Cer	Tillicate of D		2. Date of Death	g. No. ∠ U	1 6-	3. Time of Death
Physicia /Medic		DORIS S. K	ELL			Month	03	Year 2012	0745 M
Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or l			4c. County		
		Sunrise Assisted Living 5. Social Security Number 6. Sex 7. Age (In yrs. Ia	et hirthday)	Annapoli	S If Under 24 Hrs.	8. Date of Birth	Anne A		le L lace (State or Foreign
Funeral Director		146-12-8827 1□M 2 Z F 88	Yrs.	Months Days	Hours Min.	08/16/1	923	New	York
yland how		Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Lo	cation				10	Od. Inside City Limits
e Mar	cto	NJ Hudson N	orth B	Bergen					1 □ Yes ¾□ No
th the	Dire	10e. Street and Number		10f. Zip Code		10	g. Citizen of W	/hat Coun	try?
23a	ra	8300 First Ave.		07047			USA		
should be filed within 72 hours after death with the Maryland und Mental Hygiene. I will mental Hygiene and the filed within that wateral", or items 23a or 28a-f show umatic event, the Medical Evention mast be notified.	/ Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 12. Was Decedent Ever in U.S Armed Forces? 1 □ Yes 2 ▼ No If Yes, Give	1	Was Decedent of His fYes, specity Cubar 1 □Yes 2 ☑ No	spanic Origin? (Spanic Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		e - Americ k, White, e	etc.
hours atural",	ted by	3 ★ Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education	16a. Deced	tent's Usual Occupa	tion	1	6b. Kind of Bu	77.1	iite
ithin 72 ne. nan "na	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)		kind of work done du DO NOT use retired)	uring most of worki	ng	Human l	Resou	ırce
filed w Hygiel other th	e Co	12 02 17. Father's Name (First, Middle, Last)	Per	sonne1	18. Mother's Name				
ld be lental ked c	To Be	UNK Sige1			UNK Gel	lert			
shou ind M mar	-	19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street a	nd Number or Run	al Route Number,	City or Town,	State, Zip	Code)
and 2 lealth a m 27 is		Joyce Miller Niece		Harbor D			D 21403		um Ctata
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if it em 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modeal Event in the Item Collection once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	metery, cren antic	sition (Name of natory or other place Crematory	01/0	4/2012 G			
permit Depar Impor any In		21. Signature of Funaval Service Licensee	L L	2. Name and Address lardesty F		ome P.A.	12 Ric Annapo	dgely olis,	MD 21401
		23a, Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.	. Do not ent	er the mode of dying	g, such as cardiac	or respiratory arre	st,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	UN	ଦ				1	Onset and Death
/Medical Examiner		resulting in death) Due to (or as a consequ	ence of):	•					
D =	ner	Sequentially list conditions, if any, leading to immediate cause. Finer Underlying	ence of):						W.
xecute and il-trans	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of the consequen							
cate be executed physician and the burial-transit	dical E	d							
rtificat ng phy as th									
To the Hospital or Attending Physician: The law requires that the death certifulin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown		23d. Date of delivery Month Day Year					
s that gned b	by Pr	Part II. Other significant conditions contributing to death but not resu	Iting in the u	nderlying cause give	n in Part I.				he cause of death?
equire en siç					-	1 □ Ye	s 2 No	3 ☐ Prob	oably 4 Unknown
The law re the has be age 2 sho	Completed					24a. Was ar autopsy perform 1 □ Yes 2	ned?	Were auto prior to co death? 1 □ Yes	ppsy findings available mpletion of cause of
ian: rtifica stor, p	Be C	25. Was case referred to medical			26. Place of Deat				
hysic his ce	To E	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 I	ER/Outpatier	nt 3 □ DOA Othe	4 Nursing Ho	me 5 Reside	nce 6 Oth	er (Specif	AF
nding Pl ath. r: After tl e funeral	ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	Work'	rat ? res 2 □ No	28d. Describe ho	w injury occurr	red	
al or Atters after des	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At house building, etc. (Specify	me, farm, str	reet, factory, office		28f. Location (St. City or Town		er or Rura	al Route Number,
To the Hospital or within 24 hours afte To the Funeral Dir. completely filled in 1	Medical (29a. Certifier (Check only one) Certifying Physician: To the best of my know and manner stated.	vledge, deat ion and/or in	th occurred at the time time times tigation, in my open	ne, date and place pinion, death occur	and due to the cared at the time, da	ause(s) and m ate and place,	anner as s and due to	stated. o the cause(s)
To th withii To th comp	Me	29b. Signature and title of certifier What Denta	m	29c. License	21438	25	od. Date signe	d (Month,	Day, Year) 03 2012
10		31. Name and address of person who completed cause of death (Item WICHAEL J. La FENTA WM 4	23a) (Type,	EFENSE	Hwy +	ANNAPT	BLIS M	NDZ	1401
Sta Registr		31. Date filed (Month, Day, Year) JAN 0 5 2012 32. Registrar's Signat	M.	park					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 Year 6:47 P M January John Edward Kea Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11502 1st Street Thurmont Frederick 5. Social Security Number 7. Age (In yrs. last birthdav) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🖾 M 2 🗆 F Days Hours 1933 South Carolina 248-50-7756 78 Yrs Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County rem 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c City Town or Location 10d Inside City Limits Director 1 ☐ Yes 2 🛣 No Maryland Thurmont Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21788 United States 11502 1st Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status ed Forces? rmed Force.

X Yes 2 No
f Yes, Give Korean
Pates. War Black White etc 1 Never Married 2 Married þ If Yes, Give Year or Dates. 1 Yes 2 No Specify: White 3 ₩ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Paper Manufacturing should be filed with and Mental Hygien is marked other th Designer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Department of Health and Ments Important: If item 27 is marriany injury or any injury Beulah Charles Kea 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Milstead / Daughter 7184 Prospect Drive, Thurmont, MD 21788 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State January Resthaven 1 🖾 Burial 2 🗌 Cremation 3 🖺 Removal from State 2012 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Memorial Gardens ResthatemssPlaneral Services, Skkot Cody P.A. Frederick, MD 21701 9501 Catoctin Mountain Hwy. a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or linjury that initiated events Exami and Due to (or as a consequence of): resulting in death) Last physician a Physician/Medical as attending | IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 2 No the Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cerebro Vascular disease, Caro tid Arten 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed een Stenosis, Hypertension, Hyperlipidemia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed? Yes 2 No 2 No 1 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XNo 1 Yes မြ 1 Inpatient 2 ER/Outpatient 3 DOA eral Director: After this filled in by the funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 \square Pending 1 Natural Natural
Accident
Suic work 1 Tes 2 🗌 No hours after death. Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

that the death certificate be P.O. Box 68760 Division of Vital Records, To the Hospital or Attending Physician: within 24 hours a

To the Funeral C

completed filled

Maryland 21215-0036

Baltimore,

State

Registrar

Medical

29a. Certifier (Check

only one 29b. Signature a

JAN 0 6

M.D

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person

Thomas Johnson Ct SwiteC. 85 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2012 10:10P M Carl Warren Kendrick, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Atlantic General Hospital Worcester Berlin 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 ☑ M 2 🗆 F Months Days Hours Min 422-90-5919 56 Yrs Director Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location the Medical Examiner must be notified at Director 1 Yes 2X No DE Sussex Ocean View 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with items 23a 19970 Daisey Ave. USA 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14 Bace - American Indian Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. should be filed within 72 hours after d and Mental Hygiene. is marked other than "natural", or i δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Coal Miner Mining permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event; ; Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Carl W. Kendrick, Sr. Martha Dutton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty S. Kendrick wife Daisey Ave., Ocean View, DE 19970 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 CCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/4/2012 Millsboro, DE State Crem. 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 2181 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on a chiling Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) (or as a consequ Examiner Securitiesly list randitions if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Dav 5 Other (specify) Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown ed by the a detached f 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Division of Vital Records, 1 🗌 Yes Completed plnous 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s autopsy performer Yes 2 this certificate DaKI 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 2 No 1 Tyes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural injury 5 Pending Accident Endrick Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Proctorier: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one) 29b. Signature and title of certifier 30. Name and address of person wh

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State Registrar

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Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #2 Per PHY G925 3/07/2012 JH State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 1 - State Registrar Certificate of Death 2. Date of Death 01-08-2012 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ M91/09/2012 3:56 A_{M} Lorraine Alberta Kelley Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Worcester Berlin Atlantic General Hospital If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthdav) 8. Date of Birth **Funeral** 1 □ M 2 🕱 F Months Days Hours Min 05/19/1929 MD' **Director** 215-26-9175 82 Usual Residence of Decedent 10a. State 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director ms 23a or 28a-f sl must be notified Pocomoke City 1 X Yes 2 No MD Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21851 USA 1210 Market St., Apt. C-2 permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black. White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify If Yes, Give Year or Dates Specify: White 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Rosa Roberts Isaac Holland Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O. Box 141, Pocomoke City, MD, 21851 Belinda MIller / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 Removal from State Salisbury Crematory 01/10/2012 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) ture of Fundal Service Licensee 22. Name and Address of Facility Holloway Funeral Home P.A. 107 Vine St., Pocomoke City, MD, 21851 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ ARDIOPULMONARY Medical Examiner resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Non 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe after death.

Director: After this certificate to the funeral director, page 1 Yes 2 No Yes 2 K Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifies Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2. No Other: မ 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, completed filled in by determined Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

State

Date filed (Month, Day, Year)

29b. Signature and title of certifier

MO

1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Glenn K. Arzadon, MD 9714 Healthway

Registrar

29c. License number

D58755

Drive Berlin. MD 21811

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death I. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 2012 ам January 5:00 Lucy Marie King Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Silver Spring Montgomery Holy Cross Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 223-38-1010 **Director** 1 M 2 F 78 Yrs May 19, 1933 VA Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at with the Maryland Director 1 Yes 2 K No MD Anne Arundel Odenton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21113 USA 644 Lions Gate Lane death v Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11 Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married Yes þ Baltimore, Maryland 21215-0036 hours after White 1 Yes 2 X No Specify: Specify: If Yes Give 3 ₺ Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Cleaning 6 Housekeeper Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) should be file and Mental H is marked ot မ Andrew Clyde Corbin Maggie Nicholson other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or Att 644 Lions Gate Lane, Odenton, MD 21113 Robin McGuire/Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Jan. 13, 1 X Burial 2 Cremation 3 Removal from State Gate of Heaven Cemetety 4 Donation 5 Other (Specify) Silver Spring, MD 2012 21. Signature of Funeral Service Licensee

Francis J. Collins Funeral H
500 University Blvd. W., Sil

23a. Pand. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. Silver Spring MD Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Respiratory Failure disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Acute Stroke Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examin Pneumonia that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No ρ Year Month 5 Other (specify) Pregnant at time of death signed by the at d be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4X Unknown Anemia, Type II Diabetes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page 2 performed? Yes 2 No death? 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 X No ဂ 1 x Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica filled in by the

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road, Silver Spring, MD 20910 Majid Rahmanian, MD

6 Could not be

determined

31. Date filed (Month, Day, Year)

3 🗌

2. Registrar's Signature JAN 10201

State

Registrar

Medical

29a. Certifier

only one) 29b. Signature and title of

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D66372

29c. License number

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year) January 9, 2012

Registrar

DHMH 17 Rev 06-2011

State

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

of Vital

Division

31. Date filed (Month, Day, Year) 2012

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State C	of Maryland		irtment <i>tificate</i>			ınd M		giene Reg. No. 2	012	01732		
			Decedent's Name (First, Middle, Last)	-						2. Date of Dea	eath 3. Time of Death				
	Physicia Medic		Floyd Kee	esee						Month Januar	rv 14. 2012 8:40 A				
-	Examin		4a. Facility Name (if not institution, give street and num					Location of	Death		-	nty of Deat	th		
-			235 Paca Street, Apt 20)2				rland					Legany		
	Funeral Director		5. Social Security Number 216-38-1821 6. Sex 1 🖫 M 2 🗆 F	7. Age (In yrs. last	t birthday) Yrs.	If Under 1 Months	Days	If Under 2 Hours	Min.	8. Date of Birtl (Month, Day 01/31/	Year)	Co.	thplace (State or Foreign untry) oginia		
	, MO H	,	Usual Residence of Decedent 10a. State 10b. County	10.00									10d, Inside City Limits		
	ryland -f sh ied a	당	MD Allegany	10c. City,	Town or Loc	berla	nd						1 X Yes 2 No		
	e Ma r 28a notif	Director	10e. Street and Number			10f. Zip (10g. Citizen o	of What Co			
	n with the rs 23a const be	Funeral	235 Paca Street, Apt 20)2			2150	02			Tog. Onizerre	USA	, and y		
920	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed by Fur	11. Marital Status 1 Never Married 2 □ Married 1 Never Married 2 □ Married 1 □ Yes If Yes, Gir Year or Div	2 🕅 No re	li li	Vas Decede Yes, specif	y Cubar	n, Mexican,	in? (Spec Puerto F	cify Yes or No- Rican, etc.)	В	14. Race - American Indian, Black, White, etc. Specify: White			
0	hour: natur iical I	lete	15. Decedent's Education		16a. Deced	ent's Usual	Occupa	ition			16b. Kind of				
218	in 72 e. nan "i	m d	(Specify only highest grade completed, Elementary/Seconday (0-12) College (1		(Give l life, D	ind of work NOT use r	done di retired)	uring most	of workin	ig .					
7	with gient ner th		9	<u> </u>	Ja	nitor	,				Inc	lustr	ial		
land	I be filed within fental Hygiene. rked other thar tic event, the M	To Be	17. Father's Name (First, Middle, Last) James Paul	Ke	esee				r's Name Ruby	(First, Middle, Ha	Maiden Surna llzelte		Hogan		
Baltimore, Maryland 21215-0036	d 2 should be file alth and Mental I 27 is marked o r traumatic eve	19a. Informant's Name/Relationship (Type, Print) Bernice O. Bennett / Sister 237 Tara Way, LaVale, MD										lumber, City or Town, State, Zip Code) 21502			
nore,	ge 1 and nt of Hea :: If item or othe		20a. Method of Disposition 1 🌠 Burial 2 □ Cremation 3 □ Removal from	State cen	netery, cren	sition (Name	ner place			/2012	20c. Locatio	-	Town, State		
altin	permit. Page 1.8 Department of H Important: If ite any injury or ot		4 Denation 5 Other (Specify) 21. ignal re Funeral De Ligensee	Joung									Home, P.A.		
ñ	Dep Imp any onc		Merce Clopro	5		104 De	ecat	ur St	reet	, Cumbe	erland		21502		
m.S.	Physician/	3 1	23a. Part 1. Enter the disease, of complications that shock, of heart fallure. List only one cause on ear Immediate Cause (Final disease or condition										Approximate Interval Between Onset and Death		
hers'	Medical Examiner		resulting in death) Due to	(or as a consequer	nce of):										
	sit sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury												
	ate be executed bhysician and the burial-transit	Еха	that initiated events c. Due to (or as a consequence of):												
09	tte be hysicie he bui	d													
	rtifica ing pl e as t	/Me	IF FEMALE:												
Box 687	e death certificate be executed the attending physician and hed for use as the burial-transi	Physician/Me	in the past 12 months?	tcome of pregnance Birth 2 Fetal contract time of deal nown	death 3	Ectopic pr Other (spe		4				23d. Date of delivery Month Day Year			
P.O.	requires that the der been signed by the s should be detached		Part II. Other significant conditions contributing to c		ting in the u	nderlying ca	ause giv	en in Part I.		23e. Did to	bacco use co	ntribute to	the cause of death?		
ds,	quires en siç ould b	ted	Old Cerebrovascular A	ccident						1 🗆 '	res 2□No	3 🗆 P	robably 4 Unknown		
Division of Vital Records,	has has	Completed by								24a. Was a autop perfo 1 \(\sum \) Yes	sy rmed?	prior to death?	utopsy findings available completion of cause of		
a	ician: The certificate rector, pag	Be C	25. Was case referred to medical examiper?				26. Pia	ice of Deati	h <i>(Check</i>	_	1				
₹	hysic his ce I dire	ြု	1 Yes 2 No Hospital:	Inpatient 2 - El	R/Outpatier	t 3 🗆 DO	A Othe	r; 4 🗌 Nui	rsing Hor	me 5 🛣 Resid	ence 6 🗆 C	ther (Spec	cify)		
on of	Attending Pl er death. ector: After th by the funeral	Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	of injury 2: th, Day, Year)	8b. Time of injury	28 M	c. Injury work' 1 🗆			8d. Describe h	ow injury occ	urred			
ivisio	lor Atte after de Directo			of Injury - At hom ng, etc. (Specify)	e, farm, str	eet, factory,	office		2	28f. Location (S City or Tow		nber or Ru	ral Route Number,		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	29a. Certifier 1 Certifying Physician: To the b (Check 2 X Medical Examiner: On the ba only one) 3 Certifying Nurse Practioneft	sis of examination a	and/or invest	igation, in m	ny opinio	n, death occ	curred at	the time, date a	nd place, and	due to the	cause(s) and manner stated.		
	To the within 2	-	29b. Signature and title of certifier	W			License	number	,		29d. Date sig	ned (Mont			
	716S		30. Name and address of person who completed cau. Paul Snow, M.D., 124	se of death (Item 2 West Thi	3a) (Type, F	rint)	Cur	nberla	and.	MD 21	 502				
	Star Registra			Registrar's Signatur											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Florence T. Kyle 2. Date of Death Physician/ onth Januar Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Laurel Regional Hospital Prince George's dure 1 . Social Security Number 7. Age (In yrs. last birthday) 87 Yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🗆 M 2 🔀 F 226-32-3383 Months Days Hours Min. (Month, Day, Year) 8/23/1924 **Director** Glasgow. Usual Residence of Decedent 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Prince Georges Director Laurel 1X Yes 2 ☐ No 10e. Steet and Number iarcroft Ln. 10f. Zip Code 20708 10g. Citizen of What Country? Funeral USA items within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin ð ☐ Yes Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 XNo Specify: If Yes, Give Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 7th College (1-4 or 5+) Self Homemaker Be 17. Father's Name (First, Middle, Last)
Meshaeh Thomson 18. Mother's Name (First, Middle, Maiden Surname)
Lelia Anthony မ 19a. Informant's Name/Relationship (Type, Print)
Lola Early / daughter 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code)
7209 East Forest Rd. Landover, MD. 20785 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State Evergreen Cemetery 1/14/12 4 ☐ Donation 5 ☐ Other (Specify) Glasgow, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility NE Washington st. Dunn & Sons-5635 Eads 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ neumonia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Dav 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No 은 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and 29d. Date signed (Month. Dav. Year) 2012 Laurel, MD 7300 Van Dusen Road no completed cause of death (Item 23a) (Type, Print) aurel Regional Hospita 20707 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ 7:40 A. M Ernestine King 2012 January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Clinton Southern Maryland Hospital Center If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthdav) 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours (Month, Day, Year) **Director** 1 □ M 2 🔽 F 233-66-2857 67 Kentucky Aug.11, 1944 28a-f shov 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director MD Prince Georges Clinton 1 🙀 Yes 2 🗆 No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral death with 6208 Hellen Lee Drive United States 20735 items 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status "natural", or iter dical Examiner Black, White, etc. 0. 1 Never Married 2 Married Completed by 1 Yes If Yes, Give within 72 hours after 2**x** No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: White 3 Widowed 4 Divorced Year or Dates event, the Medical Decedent's Education 16a, Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Booking Agent 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental h Important: If item 27 is marked any injury or con-ပ Joseph Franklin Roberts Kathryn Lawson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathryn Danielle Wilson/Daughter 11472 Rawhide Road, Lusby, MD 20657 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Geo. Wash. University Medical Center 1 Burial 2 Cremation 3 Removal from State Jan. 4 Donation 5 Other (Specify) Washington, D.C. 2012 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Columbia Mortuary Services, P.A. /M00969 9013 Annapolis Road, Lanham, MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician OBSTRUCTIVE CHRONIC disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Box 68760 the as the attending IF FEMALE: for use 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 month 1 Yes 2 No Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Linknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by NEUMONIA Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No certificate has page 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No ျှ ER/Outpatient 3 DOA 1 Inpatient 2 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Director: After 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after within 24 hours a

To the Funeral C Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DEVATHI SURRACTS RD, CLINTON 32. Regis State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Certificate of Death Reg. No. Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 \mathbf{P}^{M} James Brian Liljegren January 1:00 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery If Under 1 Year Social Security Number If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Hours 218-56-3853 **Director** 1 X M 2 - F 62 Oct. 9, 1949 Usual Residence of Decedent Washington, DC 28a-f shov 10c. City, Town or Location ms 23a or 28a-f shormust be notified at 10a. State 10b. County the Maryland 10d. Inside City Limits Director 1 Yes 2 X No Maryland Severna Park Anne Arundel 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? with 1 Funeral 807 Cypress Beach Road 21146 United States items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, er than "natural", or ite Armed Forces? Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir þ 1 Never Married 2 M Married Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 👿 No Specify. White Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Manager Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ervin James Liljegren Betty Jean Freize 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Lynn Liljegren/Spouse 807 Cypress Beach Road, Severna, MD 21146 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 01/07/2012 Rockville, MD Rockville Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility DeVol Funeral Home nellen MO1202 10 E. Deer Park Drive, Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ Ventricular Fibrillation Minutes disease or condition Medical resulting in death) **Examiner** Advanced Atherosclerotic Cardiovascular Disease Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine ig B Diabetes Mellitus Type I and Due to (or as a consequence of): use as the burial attending physician Physician/Medical requires that the death certificate be Hypertension Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ģ in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death signed by the at Id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Coronary Artery Disease, Hyperlipidemia 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Peripheral Artery Disease 24a. Was an page 2 this certificate has autopsy performed Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No ပ 1 X Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 X Natural 5 \square Pending injun Accident Investigation 6 Could not be Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

To the Hospital or Attending Physician: T within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the

State

Medical

JAN 05 Registrar

29a. Certifier

(Check

only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

aw

Rajan Shyamsundar,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9801 Georgia Avenue, Suite 117, Silver Spring, MD 20902 32. Registrar's Signature

X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month. Day, Year,

January 1, 2012

29c. License number

D53367

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0412 A M Month 11-2012 Nancy M. Leary Medical 4c. County of Death Harford 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Havre de Grace Harford Memorial Hospital 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex Funeral 7. Age (In yrs. last birthday) 1 🗆 M 2 💢 F Days Hours Min. 02-01-1927 Marijland 220-22-3066 84 Director Usual Residence of Decedent show 10d. Inside City Limits 10b. County 10c, City, Town or Location death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director 1 X Yes 2 I No Maryland Harkord Havre de Grace 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral United States of America 301 Commerce Street, Apt. 1 21078 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. ģ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Yes, Give Completed 3 X Widowed 4 Divorced Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 16b. Kind of Business Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working (Specify only highest grade completed) life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Family Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Naomi Winkler Leroy McMaster 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Frederick Poughkeepsie (nephew) 8 Remington Road, Port Deposit, Maryland 21904 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a, Method of Disposition RA Ferris & Co. Inc. 01-12-2012 1

Burial 2

Cremation 3

Removal from State WestChester, Pennsylvania 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Zellman Funeral Home, 21. Signature of Funera P.A 21078 Washington St. Havre de Grace Maruland e of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death complications that caused the death. Do not enter the pro-23a. Part 1. Enter the disease shock, or heart failure. List only one cause on each line EUNON Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or Injury Examine Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate has I 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 1. Inpatient 2 ER/Outpatient 3 DOA ပ 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 1 Natural work? 5 Pending 1 Yes 2 No Investigation __ Accident after death filled in by the 6 Could not be ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier To the Hosp within 24 ho To the Fune completed fi Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person State Registrar

	nd Item 3/2012	7	Please Type or Print in Blace WCHD/JW per State of Maryland / D State Funeral Home Registrar		lealth and Mental Hyg	giene 2012 01737
	Physicia Medic	n/	1. Decedent's Name (First, Middle, Last) Carol Ann Lowery	Gertineate of L	2. Date of Dea Month	ath 3. Time of Death (1974) M
0	Examin		4a. Facility Name (if not institution, give street and number) Western Maryland Regional Medical	Center 4b. City, Town, or	Location of Death Cumberland	4c. County of Death Allegany
	Funeral Director			hday) If Under 1 Year Months Days Yrs.	Hours Min. 8. Date of Birt (Month, Date of S)	y, Year) Country)
	yland -f show ied at	ctor	10a. State 10b. County 10c. City, Town	or Location erland		10d. Inside City Limits 1 🔀 Yes 2 □ No
	ith the Ma 23a or 28a st be notif	Funeral Director	10e. Street and Number 11118 Forest Ave. NE	10f. Zip Code 21502	2	10g. Citizen of What Country?
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho amy injury or other traumatic event, the Medical Examiner must be notified at once.	ğ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces 1 Yes 2 No If Yes, Give Year or Dates,	13. Was Decedent of Hi If Yes, specify Cuba 1 Yes 2 X No	14. Race - American Indian, Black, White, etc. Specify: White	
Maryland 21215-0036	72 hours in "natur Medical J	Completed	15. Decedent's Education 16a. (Specify only highest grade completed)	Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired)	during most of working	16b. Kind of Business/Industry
212	d within ygjene. her tha	Be Col	Elementary/Secondary (0-12) College (1-4 or 5+)	Homema		Own Home
land	d be filed fental H irked of tic ever	To B	17. Father's Name (First, Middle, Last) William Richard Turbin		18. Mother's Name (First, Middle, Doralee Kathe:	
Mary	d 2 should alth and N 27 is ma er trauma		19a. Informant's Name/Relationship (Type, Print) Kenneth Lowery -Husband	Mailing Address (Street a	and Number or Rural Route Numbe Ave. NE, Cumbe	r, City or Town, State, Zin Code) r Land, MD 21502
Baltimore,	Page 1 an nent of He int: If item iry or othe		1 🗆 Burial 2 🗆 Cremation 3 🗆 Removal from State cemeter	f Disposition (Name of ry, crematory or other place	Date istry 1/6/2012	20c. Location - City or Town, State Hanover, MD
Balti	permit. I Departm Importa any inju		21. Signature of Funeral Service Licensee Loughly Misk & Molo80	22. Name and Addres	ss of Facility C&A Remov	
	Physician/		23a. Part 1. Enter the disease, or complications that caused the death. Do n shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition esulting in death)	_	ng, such as cardiac or respiratory ar	Interval Between Onset and Death
	Medical Examiner	Je.	Due to (or as a consequence of	Of):	EN-LUNCTIE	
	e executed sian and urial-transit	I Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Due to (or as a consequence	FUENE,	SIPCHERU	THEMMY YEARS
09289	cate be physici s the bu	ledica	d			
Вох	the Hospital or Attending Physician: The law requires that the death certificate be hin 24 hours after death. the Funeral Director. After this certificate has been signed by the attending physici the Funeral Director. After this certificate has been signed by the attending physici	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	h 3	су	23d. Date of delivery Month Day Year
s, P.O.	ires that the signed by d be detac		Part II. Other significant conditions contributing to death but not resulting in Part II. Other significant conditions contributing to death but not resulting in Part II. Other significant conditions contributing to death but not resulting in Part II. Other significant conditions contributing to death but not resulting in Part II. Other significant conditions contributing to death but not resulting in Part II. Other significant conditions contributing to death but not resulting in Part II. Other significant conditions contributing to death but not resulting in Part II. Other significant conditions contributing to death but not resulting in Part II. Other significant conditions contributing to death but not resulting in Part II. Other significant conditions contributing to the part II. Other significant conditions contributed to the part II. Other significant conditions conditions contribu	in the underlying cause gi	iven in Part I. 23e. Did t	obacco use contribute to the cause of death? Yes 2 \(\subseteq \text{No} \) 3 \(\subseteq \text{Probably} \) 4 \(\subseteq \text{Unknown} \)
Records,	ne law requirer e has been się age 2 should b	Completed by	UNDSENSIS, SIPONO	mothen		prior to completion of cause of death?
	ysician: The la is certificate ha director, page	Be	25. Was case referred to medical examiner?		1 Yes	2
of Vi	ing Physi	ate: To	27. Manner of Death 28a. Date of injury 28b.	Time of 28c. Injury work	y at k?	dence 6 ☐ Other (Specify) now injury occurred
Division of Vital	or Attendafter death Director: /	Certificate:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide Investigation Could not be determined Could not be determined Could not be determined Could not be determined Could not be building, etc. (Specify) Could not be determined		Yes 2 No 28f. Location (City or Tou	Street and Number or Rural Route Number, vn, State)
۵	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier (Check only one) 3 Certifying Physician: To the best of my knowledge, only one) 3 Certifying Nurse Practitions: To the best of my knowledge.	or investigation, in my opini	ion, death occurred at the time, date	and place, and due to the cause(s) and manner stated.
_	To the within. To the comple	Σ	only one) 3 Li Certifying Nurse Practitioner: To the best of my knot 29b. Signature and title of certifer	29c. Licens	se number	29d. Date signed (Month, Day, Year)
	M -1		On News and address of person who completed cause of death (Item 23a)	ye Jenny	MANYCAM	MARITY SX STEN
	Sta Registr		31. Date filed (Month, Day, Year) 32012 32. Rigistrar's Signature	park	1.30.001.00//	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State of Ma	•	epartment of Hea Certificate of Dea			Reg. No. 2012	01738			
I	Physicia	n/	Decedent's Name (First, Middle, Last)				2. Date of Dea	ath Day Year	3. Time of Death 1:22P M			
	Medic Examin	al	4a. Facility Name (if not institution, give street and number)	LUCK	JR 4b. City, Town, or Loc		JANUARY	7,2012 4c. County of Dea				
	LAGITIIII	CI	FREDERICK MEMORIAL HOSPITA	ΑL	FREDERICK			FREDERIC				
	Funeral	0	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	(In yrs. last birth	Months Days Ho	Under 24 Hrs.	8. Date of Birt (Month, Day	v Year) Co	thplace (State or Foreign			
	Director		220-26-5394 TELM 2 F Usual Residence of Decedent	82 Y	rs. Months Bayo		Dec. 1	1, 1929 Ma	aryland			
	and show lat	ا ا	10a. State 10b. County	10c. City, Town	or Location			Maria di	10d. Inside City Limits			
	Maryl 28a-f otified	rect	Maryland Frederick	Mor	nrovia				1 🗌 Yes 2 🗓 No			
	h the	a D	10e. Street and Number		10f. Zip Code	•		10g. Citizen of What Co				
	if filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director	11899 Lynn Crest Road 11. Marital Status 12. Was Decedent Ev	er in IIS	21770		ify Yes or No-	U.S.A.				
0	or ite	by Fi	1 Never Married 2 Married 1 Yes 2 1	Vo. 111 0.3.	13. Was Decedent of Hispar If Yes, specify Cuban, M		Rican, etc.)	Black, Whit				
ğ	ırs aft ural", IExa		3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.		1 ☐ Yes 2X No Sp	pecify:		Specify: W	nite			
<u>2</u>	72 hou "nat	Completed	15. Decedent's Education (Specify only highest grade completed)	(Decedent's Usual Occupation Give kind of work done during	n ng most of workin	rg	16b. Kind of Business	·			
12	ithin iene.	Con	Elementary/Seconday (0-12) College (1-4 or 5-	-)	ife. DO NOT use retired) uperintendant			Mechanical Contracti				
פַ	il Hyg I Hyg I othe vent,	B	17. Father's Name (First, Middle, Last)		18.	. Mother's Name	(First, Middle,	Maiden Surname)				
ylaı	should be file h and Mental I 7 is marked o raumatic eve	욘	Robert Clifton Luck				Lehman					
Maryland 21215-0036	2 should be fill th and Mental 27 is marked of traumatic ever	-	19a. Informant's Name/Relationship (Type, Print)		Mailing Address (Street and I							
e G	1 and 2 s of Health item 27 other tra		Helen M. Luck - Wife 20a. Method of Disposition		1899 Lynn Cres Disposition (Name of		Monr	20c, Location - City of				
JOIL I	Page 1 nent of ant: If it ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) Entombme	cemetery	, crematory or other place)	1		·				
Baltimore,	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other once.		21. Signature of Fuyeral Service Licensee	tr vesti	22. Name and Address of	f Facility						
m	a m a		hovert L. Willes	ner	Molesworth-W 26401 Ridge	Road	Damage	us. Marvlai	ome ad 20872			
			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line.		et enter the mode of dying, su	uch as cardiac or	respiratory an	rest,	Approximate Interval Between			
area .	Phici_n/ Medical		Immediate Cause (Final disease or condition resulting in death)			Onset and Death						
	Examiner		Due to (or as a consequence of): Coronary artery directs									
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	euritequeries c):							
	cuted ind transit	Examiner	Cause (Disease or iinjury that initiated events c.									
_	cate be executed physician and the burial-transit	al E	resulting in death) Last Due to (or as a	consequence of):							
760	cate to physical phys	ledical	d									
89	certif ending use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live Birth	of pregnancy	3 ☐ Ectopic pregnancy			23d. Date of de	elivery			
Box	death he atte ed for	sicia	in the past 12 months? 1 Yes 2 No 9 Unknown 1 Unknown		5 Other (specify)			Month	Day Year			
P.O.	at the d by t Jetach	, Ph	Part II. Other significant conditions contributing to death but	rt not resulting in	the underlying cause given in	in Part I.	23e. Did to	obacco use contribute t	o the cause of death?			
S, F	ires the signer of the signer	d by					1 🗆	Yes 2□No 3♣	robably 4 Unknown			
ord	w requ	Completed					24a. Was		utopsy findings available completion of cause of			
Rec	The lar	Com					autor perfo	rmad? death?				
ta	cian: ertifica ector, p	Be	25. Was case referred to medical examiner?			of Death (Check	only one)					
<u>=</u>	Physic this c	요	1 Yes 2 No Hospital: 1 Repair 1 Repair 28a. Date of injur					dence 6 Other (Spe	cify)			
0	ding I th. After funer	cate	12 Natural 5 ☐ Pending 2 ☐ Accident Investigation	Year) 200. II	jury work?	2 □ No	28d. Describe r	now injury occurred				
Division of Vital Records,	Atter er dea ector. by the	Certificate:	3 Suicide 6 Could not be	ry - At home, fari	n, street, factory, office	2	28f. Location (S	Street and Number or Re	ural Route Number,			
2	ital or irs afte ral Dir											
	Hosp 24 hou Fune eted fil	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of ex	amination and/or	investigation, in my opinion, d	leath occurred at	the time, date a	and place, and due to the	cause(s) and manner stated.			
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Σ	only one) 3 ☐ Certifying Nurse Practioner: To the t 29b. Signature and title of certifier	best of my knowle	29c. License nur		s, and due to th	29d. Date signed (Mon				
			> Jeff Kommand , 20		670			1/1/12				
	6		30. Name and address of person who completed cause of de		ype, Print)	relevel	e Mo	2170/				
	Stat		31. Date filed (Month, Day, Year) 32. Registra	r's Signature	parks &	,						
	Registra	ar	JAN 0 9 2012 Brown	a p.	19 aus							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . Day 2012 Month Dr. Louis Allen Liljedahl A M January 4, 8:42 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick Adamstown Buckinghams Choice 7. Age (In vrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Hours Min (Month, Day, Year) 481-30-0336 1 ★ M 2 □ F 82 Yrs March 23, 1929 Iowa Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Adamstown 1 Tes 2 X No Maryland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21710 3200 Baker Cirlce A109 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Ves 2 No Korean
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Engineer Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Irene Haggland John M. Liljedahl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11295 Woodlawn Dr., Ijamsville, MD 21754 <u>Joan Liljedahl / Wife</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Frederick, Maryland Stauffer Crematory: 1/6/2012 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, MD 21702 Tut on 23a. Part 1. Enter the disease to shook, or heart failure. List or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Immediate Cause (Final Onset and Death therosclevotic Vascular Due to (or as a consequence of) Due to lor as a consequence of Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Pregnant at time of death Month Day Year

Ph, sician/ Medical Examiner the burial-tran attending physician The law equires that the death certificate be Division of Vital Records, P.O. Box 68760 use as signed by the at has

or Attending Physician:

filled in by the funeral director,

After this

24 hours after death. Funeral Director: A

within 24 hou To the Fune completely fi

Physician/

Medical

10a. State

Examiner

Funeral

Director

28a-f show

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and Mental Hygiene. is marked other than

Department of Health ar Important: If item 27 is any injury or other trau

Director

Funeral

9

Completed

Be

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with the Maryland

within 72 hours after death

Baltimore, Maryland 21215-0036

disease or condition resulting in death) Sequentially list conditions, Examine if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical IF FEMALE 23b. Was decedent pregnant in the past 12 months? Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Diabetes 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 🔀 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) 1 🗌 Yes _2 🔀 No မ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28c. Injury at 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 🔀 Natural 5 Pending work 1 🗌 Yes 2 🗌 No Accident
Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🗵 Cert ing Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medi al Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 Certi-ring Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 1 - 6 - 2012 D0058726

Myersville

MN

Ct.

21773

State Registrar YveHe

31. Date filed (Month

Ventrie

3000 -D

32. Registrar's Signature

30. Name and address of perion who completed cause of death (Item 23a) (Type, Print)

MID

Warren

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Physician/ Month January 7 2:40 a M Donald Irving Lehman, Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Rockville Montgomery Hospice-Casey House Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthdav. 8 Date of Birth **Funeral** Days Min. (Month, Day, Year) 577-36-2450 Director 1 🖾 M 2 🗆 F June 24, 1930 Washington, DC shov ms 23a or 28a-f sho must be notified at 10a State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No MD St. Mary's Charlotte Hall the 1 10e. Street and Number 10g, Citizen of What Country? Funeral 20622 USA 29449 Charlotte Hall Road iral", or items 2 Examiner mus death \ 12. Was Decedent Ever in U.S. Armed Forces?

1XX Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after Specify: White 1 ☐ Yes 2 X No Specify: "natural", 3

Widowed 4 □ Divorced Year or Dates. 1951-53 the Medical Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 11 Truck Driver Service other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ethel Minot Irving Lehman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health Rademacher/Daughter 16929 MacDuff Avenue, Olney, MD 20832 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Jan. 13. 4 Donation 5 Other (Specify) Parklawn Memorial Park 2012 Rockville. of Funeval Service Licen Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 Part \ Elter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final nset and Death Weeks Ph sician/ Incarcerated Left Inguinal Hernia disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence oi). n and certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician for use as the buris Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Pregnant at time of death Yes 2 No 9 Unknown Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🏝 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate has autopsy performed 2 No Yes 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospice 6 Other (Specify Hospital Other: 1 Tes 2 X No ည within 24 hours after death.

To the Funeral Director: After this of completely filled in by the funeral directors. 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred or Attending 1X Natural 5 Pending 1 Yes 2 No ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Jan. 7, 2012 2 29c. License number D60634 1141

Registrar
DHMH 17 Rev 06-2011

State

1355 Piccard Drive, #100, Rockville, MD 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BIndu Joseph, MD

JAN 10

31. Date filed (Month, Day, Year,

12-00382 Robert Barrington	•						Depa	rtment	of F	. Ensure				egibl	le.	and a	2 0176
Physician	F	Registrar 1. Decedent's Name	e (First Midd	le I ast)			Cer	tificate	of L	eath			2. Date of D	Reg. No	o	3	3. Time of Death
Medical Examine		Robert			n Lloy	d Jr						- 1	Month January		Year		1022 hrs
		4a. Facility Name (i	f not institution	on, give s				<u>-</u>		City, Town, or	Location	of Death			c. County of		
	Ļ	22722 Roya				7 A (1-		at history		Quantico If Under 1 Yea	e I If I In.	der 24Hrs.	To Date of		Wicomico		hplace (State or
Funeral Director	- 1	5. Social Security N 218-48-68		6. Sex	1 2 F		65	st birthday)	ı	Months Day	_		Oct.			Foreig	
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the Maryland n or 28a-f sh	9	10e. Street and Nur 22722 Ro		ak Ro	oad				1	Of. Zip Code 21	.856			_	itizen of Wha nited		-
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiera Marturality or items 23a or 28a-f she Important. If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once TO De Completed by Ermonel Director		11. Marital Status			12. Was Dec	edent Eve	er in U.S	S. 113. V	Was D	ecedent of His		rigin? (Spe	ecify Yes or				can Indian, Black,
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s after c		3 Widowed			Yes, Give Yee r Dates:	1966	-19			es 2 No					Specify.	Whi	
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21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the Medica		17. Father's Name	(First, Middle	, Last)							18. M oth	er's Name	(First, Midd	e, Maide	n Surname)		<u> </u>
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Baltimore, permit. Pages I ar Department of Hee Important: If ite Important: If ite Imjury or other tr	ł	21. Signature of Fu			•				-	e and Address	-				Some:		
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Physician /Medical Examiner	1	23a. 7 art I. Enter th failure. List onl Immediate Cause (or condition resulting	ly one cause Final disease ng in death)	on each	line.	ic(o	xymo	orphon		and fen						T.	Approximate Interval Between Onset and Death
ted Insit	Karminer	if any, leading to im cause. Enter Unde (Disease or injury to events resulting in	mediate rlying Cause hat initiated	c. Du	e to (or as a												
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. the death certificate be execut by the attending physician and sched for use as the burial - tra	ysician	23b. Was decedent past 12 months 1 Yes 2 1	?		1 Live b 4 Pregn 9 Unkno	ant at time	e of dea		Fetal Other	death 3 (Specify)	Ectop	oic pregnar	ncy		Month	C	ay Year
P.O. I	<u>}</u>	Part II. Other signi	ficant condit	tions co	ontributing to	death bu	ıt not re	esulting in th	e und	erlying cause g	given in I	Part I.					the cause of death? ably 4 🗹 Unknown
Division of Vital Records, P.O. Box 68760, rith the Bopital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Function: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buring direct or the page 2 should be detached for use as the buring director.	Completed												pe 1 ✓ Ye	as an topsy rformed s 2	pri de		topsy findings available ompletion of cause of s
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D To the Hospital within 24 hours To the Funeral completely filled	<u> </u>	29a. Certifier 1	Certifying P Medical Exa	miner: O	: To the bes n the basis on nd manner s	of examina	nowledg ation ar	ge, death oc nd/or investi	currec	at the time, da	ate and p	place, and o	due to the ca	ause(s) a	and manner a	as state	ed.
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1	- 1	Name and address	ess of person	who cor	npieted caus	se of death	n (Item	23a)									

State Registrar

31. Date filed (Month, Day, Year) JAN 19 2012

DOME

Patricia Aronica-Pollak MD.

original

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ 2012 p^{M} January 1:45 Me1cher Clarence John Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Bethesda Suburban Hospital If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 213-26-6879 81 **Director** 1**X**□ M 2 □ F NY Yrs. Feb. 18, 1930 Usual Residence of Decedent or 28a-f shov 10d. Inside City Limits 10a. State 10c. City, Town or Location must be notified at Director 1 Yes 2 X Nő Silver Spring MD Montgomery 10g. Citizen of What Country? 10e. Street and Number Funeral "natural", or items 23a 20906 USA 3210 North Leisure World Blvd., #1004 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Black, White, etc. 1 Never Married 2 Married þ should be filed within 72 hours after and Mental Hygiene.
is marked other than "natural". or Specify: White 1 Yes 2 X No Specify: Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4 or 5+) Elementary/Secondary (0-12) Telecommunications Manager Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marken any injury or other traumatic e once. Clarence John Melcher, Sr. Ruth Olssen other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3210 North Leisure World Blvd. #1004, Silver Spring, MD Alma Melcher/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🗆 Burial 2 🔀 Cremation 3 🗷 Removal from State Jan. Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2011 Alexandria, VA 21. Signature of Funeral Service Licenses Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 2 MOS Immediate Cause (Final MALIGNAM MESOTHELIUMA Physician PLEUNAL disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence on Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) Box in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4SPINATION PNEUMONIA 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy • Hospital or Attending Physician: The 24 hours after death. Funeral Director, After this certificate I 1 ☐ Yes 2 ☐ No 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) Certificate: To Be Other: 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time o 28d Describe how injury occurred Natural Accident 5 Pending Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of cert 29c. License number JAN. 5, 2012 D-23308 completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

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31. Date filed (Month, Day, Year)

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ROCKLEOGE DRIVE BETHESOA MD. 20817

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First Middle | ast) 2. Date of Death 3. Time of Death Physician/ 17 7012 8:30 PM JUM HENRY John James Macuci Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Washington Medical Center Anne Arundel Glen Burnie 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 **M** M 2 □ F **Director** 077-18-4240 March 14, 1923 New York 88 Usual Residence of Deceden 28a-f show 10b County 10c. City, Town or Location 10d. Inside City Limits 10a. State notified at Director 1 Yes 2XX No District Heights Maryland Prince Georges 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? must be n Funeral U.S.A 20747 7110 Lansdale St. items 2 death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status 12. Was Decedent Ever in U.S. the Medical Examiner Armed Forces? ö þ 1 Never Married 2 XXMarried within 72 hours after Saltimore, Maryland 21215-0036 Specify: White 1 Yes 2 X No Specify: If Yes, Give Year or Dates. "natural", Completed 3 Widowed 4 Divorced WII 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Operating Engineer HVAC Maintenance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be a Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ewo ပ Michael Macuci Anna Montella 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8621 Fluttering Leaf Trail Unit 404 Odenton, MD 21113 Sharon Macuci (Daughter) Method of Disposition

1 → Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, January 12, 2012 Mt. Olivet Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Washington, DC 22. Name and Address of Facility Lee Funeral Home, Inc. 21. Signature of Funeral Service Lice MO1555 6633 Old Alexandria Ferry Rd. Clinton, MD 20735 Approximate Halt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on , ach line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence or). Cause (Disease or injury that initiated events resulting in death) Last the burial-tran and Due to (or as a consequence of): ding physician Physician/Medical use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) signed by the at Id be detached fo g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Tyes 2 No 3 ☐ Probably 4 ☐ Unknown Completed should peen Lal or Attending Physician: The law requare for death.
Its after death.
In Birector: After this certificate has bear all Director. After this certificate specific the second of the sec 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ► No 24a Was an autopsy 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital o within 24 hours af To the Funeral Di completely filled in Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier partinger: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 3 Certifying title of certifi 29b. Signature a 48000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nn State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Franklin Joseph Mackall /2/201 19 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert Memorial Hospital Prince Frederick Calvert Social Security Numbe 8. Date of Birth (Month, Day, If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Months Days Hours Min (Month, Day, Year) 8 / 9 / 1 9 4 8 Country) 63 Director 217-46-8684 MD Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD Calvert 1 X Yes 2 No North Beach 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral 23a 9000 Bay Avenue #209 20714 USA or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 👿 No Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", Yes. Give Completed 3 Widowed 4 Divorced Year or Dates. Black the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Painter Building 12 other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental h ည Daniel Mackall Helen Elizabeth Kyler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Kathryn Mackall/Wife 9000 Bay Ave. #209, North Beach, MD 20714 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Page 1 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crem. 1/9/12 Beltsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Raymond-Wood F.H., P.A. 430 Dunkirk, MD 20754 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of Exami and as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be e 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 IF FEMALE nse 23c. If yes, outcome of pregnancy
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1 Yes 2 No
9 Unknown jo Pregnant at time of death 5 Other (specify) ed by the a detached f g 🔲 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 ☐ Yes 2 ☐ No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: ည 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred M Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation completed filled in by the 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 3 only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 01/3 53298 address of person who cor eted cause of death (Ite Type, Print) DRW Road Hospitai Kink Frederick into 20078 31. Date filed (Month, Day, Year 32 Registra State JAN Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 01745 For

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	Funeral		5. Social Security Number 6. Sex		. last birthday)	If Under 1 Year	If Under 24		th 9.1	Birthplace (State or Foreign		
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Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type, Print) Rosemary Malecki Daug	htor				r Rural Route Numbe Arnold M	r, City or Town, State,	Zip Code)		
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Division of Vital Records, P.O. Box	fer differ diffe	Certificate:	4 Nomicide determined 286. F	lace of Injury - At uilding, etc. (Spec	home, farm, str <i>ify)</i>	eet, factory, office		28f. Location (S City or Tov	Street and Number or vn, State)	Rural Route Number,		
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1 \(\subseteq \text{ Yes} \quad 2 \subseteq \text{No} \) 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò ementia 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 N 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗆 No 1 Yes ပ 1

Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident iniury 5 Pending work? accidental ingestion 1/12 2 No Investigation unknown 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, building, etc. (Specify) farm, street, factory, office 28f. Location (Street and Number or Rural Route Number | City or Town, State) | 7 | | Nordic Hill Cir. determined home SILVER SPRING, MD 20906 Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title 29d. Date signed (Month, Day, Year, 54999 2012 January 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bichhueng M. Dinh 18101 Prince Philip 20832 31. Date filed (Month, Vay, Year) 82. Registrar's Signature State 5 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Ralph Curtis 2012 Mvers January 10:37 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Williamsport Retirement Village Williamsport Washington 5. Social Security Number 8. Date of Birth
(Month, Day, Year)
June 23, 1927 **Funeral** 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Months 1 **X** M 2 □ F Days Hours West Virginia 234-38-9527 **Director** 84 Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director Virginia Berkeley Falling Waters 1 Yes 2 No 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? ?7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be by Funeral 48 Bugler's Way Apt. 1 25419 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? 1XXyes 2 No.1944-Black White etc. 1 Never Married 2 XMarried and 2 should be filed within 72 hours after (Health and Mental Hygiene. em 27 is marked other than "natural", or Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify: If Yes, Give Specify. Completed 3 Widowed 4 Divorced 1946 Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Boiler Operator Shoe Soles Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Raleigh Wesley Myers Anna Beavers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25419 19a. Informant's Name/Relationship (Type, Print) Mary C. Myers - Wife 48 Bugler's Way Apt. 1 Falling Waters, West Virginia injury or other if item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 s Department o Important: If any injury or 1 🔀 Burial 2 🗌 Cremation moval from State Greenlawn Mem. Park Jan.13,2012 Williamsport, Maryland 5 Otb ature of Usburned Afteneradity Home, P.A. 21795 #25 S. Conococheague St.Williamsport, Maryland Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition MEUMONIA WEFVS Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events burial-tran and resulting in death) Last Due to (or as a consequence of): nding physician Physician/Medical certificate be Box 68760 as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month ed by the a detached f P.O. signed by Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ PARKINGON'S DISEASE CHRONIC OBSTRUCTIVE Division of Vital Records, 1

Yes 2 □ No 3 □ Probably 4 □ Unknown Completed Were autopsy findings available prior to completion of cause of rumonazy DISEASE 24a. Was an autopsy ☐ Yes 2 X No 1 Yes 2 No or Attending Physician: the Funeral Director: After this certific appleted filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 🔀 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 Yes 2 No 28b. Time of Certificate: 28d. Describe how injury occurred 1 🛚 Natural 5 Pending iniury 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Hospital 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29c. License number DW. SWO 1733700 P YSTAWAL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IW-3+ OVERWUS ISOONS BORD, MD IED HOWE 1542 21713 DISIVE State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ LOWANDA LOUISE MADRIC Medical JAN 2012 12:09 A 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY WRNMMC BETHESDA 5. Social Security Number Funeral . Age (In vrs. last birthday . Date of Birth 9. Birthplace (State or Foreign Country) ELAWARE Days 1 □ M 2 💢 F Months Hours Min. (Month, Day, Year, 221-52-8610 **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland s 23a or zou nust be notified a' by Funeral Director 10d. Inside City Limits oodbr 1 Yes 2 No 10g. Citizen of What Country? Woodtern 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married 9 Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. "natural", 3 Widowed 4 Divorced Completed er than "natur, Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Asst. ·+ and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည e 7 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Woodbridge, VA 22 192 Woodtern HOWI or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date of Burial 2 Cremation 3 Removal from State Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify)

21. Signa / of Funeral Service (icense 1-13-2012 New Castle, DE Bracelawn Memorial 22. Name and Address of Facility CONGO FUNERAL HOME N Gray Ave. PUBOX 2593, WILM, DE 19805 23a. Part 1. Enter the disease, or complications that caused the orath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) BREAST CANCER Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death the 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician; The law performe 2 🗌 No Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: မ 1 Yes 2 X No After this 1 Xnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 24 hours after death.

Funeral Director: After thi
sted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred X Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Accider
Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

FIVA

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GLENN W. WORTMANN,

Date filed (Month, Day, Yes JAN 11 201

MD COL

32. Registrar's Signature

0101044261

WRNMMC, BETHESDA, MD 20889 5600

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 8 2012 2012 Crilly Murphy 9:35 PMAnne Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Hospice-Casey House Rockville Montgomery Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Months Days Hours (Month, Day, Year) 102-22-0366 Director 83 1 M 2 🔀 F May 13, 1928 NY Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatih and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shoi any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 1 Yes 2 No MD Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20895 USA 4508 Dresden Street 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 2 XNo Yes Yes, Give Baltimore, Maryland 21215-0036 _{Specif}White 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Legal Secretary Law Firm 12 Be 18. Mother's Name (First, Middle, Maiden Surname)

Mary Ellen Brennan 17. Father's Name (First, Middle, Last) ဂ္ Joseph Crilly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10203 Frederick Avenue, Kensington, MD 20895 Sean Murphy/Son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Jan. 14 2012 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery Silver Spring, MD Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ Ischemic Cardiomyopathy disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami the Hospital or Attending Physician; The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) ng physician as the buria To Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 the attending phase as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ ours after death. eral Director: After this certificate has been signed by the atter filled in by the funeral director, page 2 should be detached for u in the past 12 months?
1 ☐ Yes 2 🛣 No Month Year Pregnant at time of death 1 Yes 2 X 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospice Hospital 2 🏝 No Other: 1 🗌 Yes 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1XXNatural 5 Pending 1 🗌 Yes 2 🔲 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours To the Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of Certifier 29d. Date signed (Month, Day, Year) D37142 January 9, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Coleman, MD 1355 Piccard Drive, #100, Rockville, MD 20850 31. Date filed (Month, Day, Year)

State

Registrar

JAN 1 0 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle 1 ast) 2. Date of Death 3. Time of Death Physician/ Month Day Stuart Jerome MARCUS 2012 10:00 A 8 Medical January 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Rockville 5408 Parkvale Terrace Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex.
1 X M 2 □ F 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Min. Hours Jann 23 Year 1947 Massachusetts Director <u>034-36-8416</u> 64 Usual Residence of Decedent 28a-f show "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 💢 No Rockville Montgomery Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20853 5408 Parkvale Terrace filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 X Married þ 1 Yes : Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white Completed 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of health and Mental Hygene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry
Naval Sea Systems (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Command Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anita Benson George Marcus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5408 Parkvale Terrace, Rockville, MD <u>Gershona Marcus, wife</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Dotter (Specify <u>Lebanon Cemetery : 01/10/12</u> Adelphi, MD Fur eral Porchitiky Hebrew Funeral Home 20012 254 Carroll St., NW, Washington, DC Part 1. Sate the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. 23a Part 1 Approximate Interval Between Princet and Death Immediate Cause (Final Physician/ Metastatic Lung Cancer Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and tran Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Day 5 Other (specify) Pregnant at time of death Yes 2 No the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been si rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Yes 2 No : After this certific funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 X No 1 Yes 은 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the fune 1 🛛 Natural 5 Pending 2 Accident
3 Suicide Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number January 9, 2012 D 42452 30. Name and address of person o completed cause of death (Item 23a) (Type, Print) M.D., Chitra Rajagepal 18111 Prince Philip Drive, #327, Olney, MD Date filed (Month, Day, Year) State 1 0 2012

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State PGC1-19-12CT Registra American State PGC1-19-12CT Registra American State Of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month January 07, Physician/ 2012 8:30 AM THURMAN MURPHY Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** PRINCE GEORGE'S CLINTON SOUTHERN MARYLAND HOSPITAL CENTER 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Hours 76 Yrs **Director** 237-52-9475 1 XM 2 □ F April Usual Residence of Decedent 10d. Inside City Limits show 10a. State 10c. City, Town or Location Director 1 X Yes 2 No 28a-f MD Prince George's Oxon Hill 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number event, the Medical Examiner must be Funeral 6409 Livingston Road, Apt.#104 23a 20745 20895 US Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. o 1 Never Married 2 Married ð Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Black Specify: "natural", 3 ₩Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Electronic Technician Be 18 Mother's Name (First, Middle, Maiden Surname) Winnie Minnie Bell Murphy 17. Father's Name (First, Middle, Last) 2 should be file h and Mental F ပ Edgar Farrior other traumatic (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Stre permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau once. Ave, Upper Marlboro, MD 20772 Anthony T. Murphy/Son Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Cheltenham, MD Maryland Veterans 1-23-2012 4 Donation 5 Other (Specific 22. Name and Address of Facility Pope Funeral Homes, Signature / Funeral Service Lice 5538 Marlboro Pike, Forestville, MD 20747 Part 1. Enter the disease or complicators that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Myocarcha Immediate Cause (Final Ph, sician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence oi). Examir that initiated events Due to (or as a consequence of): resulting in death) Last physician by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Day in the past 12 months? Month Pregnant at time of death 1 Yes 2 No g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Be Completed funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed' 2 1 No Yes 2 No 1 Tes this certificate 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Hospital Other: 2- 1 No ျ 1 Yes 1 Inpatient 2 FR/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural iniury work? 1 ☐ Yes 2 ☐ No 5 Pending within 24 hours after death.

To the Funeral Director: A Accident Investigation filled in by the Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifiel Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one

State Registrar

DHMH 17 Rev 06-2011

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29b. Signature and tig

31. Date filed (Month, Day, Year)

JAN 1 2 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1328 Southern

PALMER UD

29c. License number 10055 120

Ovenne SE Smt 310 WAS hington Oc 20032

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Nancy LuVern Month Morgan 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Western MD Regional Medical Center Cumberland Allegany 8. Date of Birth (Month, Day, Year) 07/10/1939 Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Hours Director 215-36-7657 1 □ M 2 💢 F 72 Maryland show or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Allegany Frostburg 1 XYes 2 No 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? must be 23a Funeral 21532 USA 100 Honeysuckle Lane, Apt 106 an "natural", or items Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black White etc Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 and 2 should be filed within 72 hours after 1 Yes 2 No Specify: 3 Widowed 4 X Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene, Important: If item 27 is marked other tha any injury or other traumatic event, the I once. Clerk Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Clarence Stewart Hilda Rice 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tammy A. Frye / Daughter 210 Delano Avenue, Frostburg, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Restlawn Mem. Gardens 01/14/2012 LaVale, MD 22. Name and Address of Facility Adams Family Funeral Home, F.A. 404 Decatur Street, Cumberland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ (00 onwo disease or condition elic years Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to lor as a considuence of Exami ig physician and as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) n signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an within 24 hours after death.

To the Funeral Director: After this certificate has I autopsy Hospital or Attending Physician: The 24 hours after death. 2 🗌 No Yes 2 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 🗆 No 1 🗌 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manne of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1- Natural (Month, Day, Year) 5 Pending work? 1 ☐ Yes 2 ☐ No Accident the Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier amination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 5 12,2012 JANUARY 30. Name and address of person with completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

Registrar

State

32. Registrar's Signature

924 Seton Drive, Cumberland, Maryland

Vik Poonai, M.D.,

31. Date filed (Month, Day, Year)

JAN12

		For State Registrar	State o	of Marylan		artment of F rtificate of a		_	giene Reg. No. 2	012	01753	
Physicia /Medica	_	1. Decedent's Name (First, Middle Betty		ae		Mills		2. Date of De Month	Day	Year	3. Time of Death	
Examine		4a. Facility Name (If not institutio Garrett Coun			ital	0a	r Location of Death kland	1	4c. Cc	ounty of Death Garrett		
Funeral Director		5. Social Security Number 217–22–6149 Usual Residence of Decedent	6. Sex 1 □ M 2 🖾 F	7. Age (In yrs. 85	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da		Coun	lace (State or Foreign try) yland	
e Maryland Sa-f show	Director	10a. State 10b. County MD	Garrett	10c. Cit	y, Town or Lo	cation Oakland				1	0d. Inside City Limits 1 □Yes 2 ▼ No	
th with th	ral Dire	10e. Street and Number 2254 Garrett	Road			10f. Zip Code 215	550		10g. Citizen of What Country? USA			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Involved Ever increment be notified at once.	by Funeral	11. Marital Status 1 ☐ Never Married 2 【 Mar 3 ☐ Widowed 4 ☐ Divorced	ried Armed Fo	2 XNo ive No		Was Decedent of H fYes, specify Cuba 1 □Yes 2 1 No	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	No- 14. Race - American Indian, Black, White, etc. Specify: White			
within 72 ho iene. than "natur ne Medical	Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12)	t's Education st grade completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done o DO NOT use retired Homema	during most of wor d)	king	16b. Kind	of Business/Ind	dustry	
d be filed ental Hyg ked other c event, I	To Be C	17. Father's Name (First, Middle, Clarence	Last) Edward	d	Wheel		18. Mother's Nam	ne (First, Middle, ice	. Maiden Su		vn)	
nd 2 shoul alth and M 27 Is marl r traumati	F.	19a. Informant's Name/Relations Vernon S. Mills		nd		ng Address <i>(Street</i> Garrett				own, State, Zip	Code)	
Pages 1 arent of Heannt: If Item		20a. Method of Disposition 1 ☐ Burial 2 ▼ Cremation 4 ☐ Donation 5 ☐ Other (S		State	-	sition (Name of natory or other place ad Cremat	i i	Date		tion - City or To		
permit, F Departm Importar any inju		21. Signature of Funeral Service		Cun	22	Name and Addre	ss of Facility Ada	ams Fami	ly Fu		Home, P.A. 21502	
Physician /Medical		23a. Part 1. Enver the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a.	caused the death	ptic	-1	ng, such as cardiad	or respiratory a	rrest,		Approximate Interval Between Onset and Death	
executed an and rial-transit	dical Examiner										(dy.	
Physician: The law requires that the death certificate this certificate has been signed by the attending physical director, page 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live	tcome of pregna birth 2□ Fetal Inant at time of d nown	Ideath 3	Ectopic pregnanc	у		230	d. Date of delive	ery Day Year	
quires that an signed b uld be deta	2	Canada Caria									ne cause of death?	
siclan: The law requir certificate has been s rector, page 2 should	Completed							24a. Was autoj perfo 1 🗆 Yes	an psy ormed? 2 No	24b. Were auto prior to co death? 1 ∐Yes	psy findings available mpletion of cause of 2 No	
ding Physiclan: h, After this certific funeral director,	n: To Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospital: 28a. Date	Inpatient 2 of Injury	ER/Outpatien 28b. Time of Injury		4 L Nursing H	th (Check only only only only only only only only	dence 6		(y)	
To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Certification: To	Natural 5 Pendin investion Suicide 6 Could determ	gation not be 28e. Place		ome, farm, stre		Yes 2 □ No	28f. Location (: City or To		Number or Rure	al Route Number,	
e Hospital	Medical Ce		ng Physician: To the Examiner: On the b									
Withir Voth Comp	Me	29b. Signature and title of certific				29c. Licens	e number	9	29d. Date signed (Month, Day, Year)			
nes	-	30. Name and address of person Robert Gora				Print) 1 Street,		1	1550	111		
State Registra		31. Date filed (Month, Day, Year)		Registrar's Signa		, Sal						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State		se Type or State o		d / Depa		Health and	Mental Hyg	iene	112 (1756		
Physici Med		Registrar 1. Decedent's Name Matilda		Last)		Martin	imodio or	Dodan	2. Date of Deat	eg. No.	3.1 3.17	ime of Death		
Exami			not institution,	give street and num		TI COLOR	,	or Location of Deat berland	h	4c. County	y of Death egany			
Funera Director		5. Social Security Number 6. Sex 1 M 2 X=			7. Age (In yrs. Ia 61	st birthday) Yrs.	If Under 1 Yea Months Day				9. Birthplace (S Country)	State or Foreign		
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faryland 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho aumatic event, the Medical Examiner must be notified at	þ	11. Marital Status 1 XNever Marri 3 Widowed	ied 2 🗆 Marr	12. Was Deced	dent Ever in U.S. rces? 2 ZeNo e			Hispanic Origin? (S ban, Mexican, Puerl	pecify Yes or No- to Rican, etc.)	14. Rad	ace - American Indian, ack, White, etc.			
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and 2. be filed wit ental Hygie ked other c event, th	To Be C	17. Father's Name (,	18. Mother's Name (First, Middle, Maiden St						n home Surname)			
5 5 € 5 €		Charles Thomas Martin 19a. Informant's Name/Relationship (Type, Print) George Pyles Drother P.O. Box 206 20a. Method of Disposition 20b. Place of Disposition (Name of							26757					
Baltimore, cernit. Page 1 and Department of Heal moortant: If item 3 my injury or other once.		1 🗆 Burial 2		3 ☐ Removal from toccify)	State C6	emetery, cren	sition (Name of natory or other po uneral Ho		Date 1/11/2012		- City or Town, St	mate MD		
Baltimo permit. Page Department c Important: if any injury or		en	neral Service Li	N	-		108	ress of Eacility Pelli Funeral I Virginia Aven	<u>ue: Cumberla</u>		1502			
Physician/		shock, or hear Immediate Cause (disease or conditio	t failure. List o Final	complications that canly one cause on each	aused the death th line.	21.2	r the mode of dy	ying, such as cardiad	or respiratory arre	st,	Interv	oximate val Between it and Death		
Medical Examiner		resulting in death) Sequentially list col		b. ———	or as a consequ							1		
be executed be executed sician and burial-transit	al Examiner													
Box 6876(death certificate ne attending phy, ed for use as the	by Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 r 1 Yes 2 9 Unknown	months?		Birth 2 Fetal ant at time of d	Ideath 3	Ectopic pregna				23d. Date of delivery Month Day Year			
cords, P.O. law requires that the nas been signed by the 2 should be detach	ed by Pl	Part II. Other signif	icant conditio	ns contributing to de	ath but not resu	ulting in the u	nderlying cause	given in Part I.			ribute to the caus	se of death?		
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ision of Vital Attending Physician: of death. sector: After this certific	ate: To	27. Manner of Death		28a. Date o	npatient 2	ER/Outpatien 28b. Time of injury	28c. Inj	4 □ Nursing hurv at	Home 5 Reside 28d. Describe ho					
Division of Vital Records, ral or Attending Physician: The law requires is after death. In Director: After this certificate has been signed in by the funeral director, page 2 should be a should by the funeral director, page 2 should be a should by the funeral director, page 2 should be a shou	Certificate:	2 Accident 3 Suicide 4 Homicide	Investig 6 Could r determi	ation not be 28e. Place of	M 1 ☐ Yes 2 ☐ No					28f. Location (Street and Number or Rural Route Number, City or Town, State)				
Hospit 24 hour Funera	Medical	(Check 2	Medical E	Physician: To the be caminer: On the basis Nurse Practitioner:	s of examination	and/or invest	igation, in my opi	nion, death occurred	at the time, date an	d place, and du	e to the cause(s) a	and manner stated.		
To the within 2 To the comple	-	29b. Signature and t	title of certifier	MIAC		,		70131			d (Month, Day, Ye			
MAS		30. Name and addre	ess of person v	ho completed cause	of death (Item	23a) (Type, P	rint)	oad G	emba.la	d M	0 = 21	502		
Sta Registr		31. Date filed (Month	n, Day, Year)	32. Re	gistrar's Signati	ure/	1			SV CX IV	V 2	30, 200		

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athleen Murph	ıy	State of 1- For State Registrar	Maryland / Department o Certificate of			2012 Reg. No.	2 0175
Physic Medical Exam			furphy	-	2. Date of Dea Month	ath 3 Day Year	3. Time of Death 1222 hrs
)		4a. Facility Name (if not institution, give stre		4b. City, Town, or Location	January 1	4c. County of Death Frederick	7222 1113
Funeral Director		5. Social Security Number 215−31−7213 6. Sex	7. Age (In yrs. last birthday) 2X F 24 Yrs	Months Days Ho	tree Miles	rth (MM/DD/YYYY) 9. Birth; Foreign 07/1987 Coun	place (State or
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, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiers tem 27 is marked other than "natural", or items 23a or 28a-fahe traumatic event, the Medical Examiner must be notified at once	Completed !	45 December 1 Street 10 15 11	ghest grade completed) 16a. Deceden	t's Usual Occupation (Givent) of working life. DO NO	ve kind of work done OT use retired)	16b. Kind of Business/Ind	dustry
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e, MD 2 1 and 2 shou Health and N item 27 is n	7	Ellen M. Murphy/ Mo	ther 8013 I	ighthouse I	umber or Rural Route Num Landing Fred	nber, City or Town, State, Z derick, Mary 20c. Location - City or To	
Baltimore, permit. Pages 1 and Department of Heal Important: If iten injury or other tra		1 Burial 2 Cremation 3 Red 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licenspe	emoval from State Smithsburg	er place) g Crematory	01/22/2012	Smithsburg	, MD
m aalii Physician		23a. Part I. Enter the disease, or complication	ris triat caused the death. Do not enter th	06 E. Church	St., Freder	Basford Funer rick, MD 2170 est, shock, or heart 17	PAL HOME Approximate Interval
/Medical Examiner			e. <u>rcotic (Morphine) Int</u> o (or as a consequence of):	oxication			Between Onset and Death
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Box 6876 e death certificat the attending ph ed for use as the	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 V Unknown 9	Pregnant at time of death 5 Oth	er (Specify)	oic pregnancy	23d. Date of delivery Month Day	Year
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Division of Vital Records, ral or Attending Physician: The law require stater death. al Director: After this certificate has been sited in by the funeral director, page 2 should be	n: To Be	examiner? 1 Yes 2 No Hospita 27. Manner of Death	I: 1 Inpatient 2 ER/Outpatient Ba. Date of Injury (Month, Day, Year) 28b. Time of Inj	3 DOA Other Ury 28c. Injury at Wor	k? 28d. Describe h	Residence 6 🗹 Other: So	zene
Division spital or Attend hours after death neral Director: y filled in by the i	Certification	2 Accident Suicide Suicide Accident Suicide Suicide Accident Suicide S	Fd 1-16-12 fd 1155 Be. Place of Injury - At home, farm, street,		etc. 28f. Location (Sf or Town, St	treet and Number or Rural F	house
To the Hospi within 24 hou To the Funer completely fil	Medical Co	29a. Certifier 1 Certifying Physician: To one) 2 Medical Examiner: On the	Residence the best of my knowledge, death occurre e basis of examination and/or investigation lanner stated.	ed at the time, date and p	Landing lace, and due to the cause	Frederick N e(s) and manner as stated.	<u>Id.</u>
		29b. Signature and title of certifier 30. Name and address of person who completed	ted cause of death (Item 23a)	O.C.M.E.		29d. Date signed (Month, January 17, 2012	Day, Year)
Sta	ate.	Zabiullah Ali, M.D. Assistant 31. Date filed (Month, Day, Year)	Medical Examiner 900 W. Ba	ltimore Street, Balt	imore, MD 21223		
Registi	rar	JAN 2 5 2012	June S. par	w	<u>. </u>		
HMH 17 Rev 1/20 DCME 2006	01		ORIGINAL			OCME	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. John Robert McDonald State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Physician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Medical Examiner McDona1d Robert 0940 hrs John January 15, 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4651 Dallas Place # 102 Temple Hills Prince George's 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Hours Min. 462-75-6379 Director 40 08/05/1971 Texas 1 X M Country) 2 F Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2XX No Marvland Prince George's Temple Hills Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other transmite event; the Medical Examiner must be notified at once Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20748 USA 4651 Dallas Place #102 12. Was Decedent Ever in U.S. Funeral 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married White, etc. ² 2008 3 Widowed If Yes, Give Year 4 X X Divorced 1 Yes 2 X No specify: White Specify: 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Editor 2 years Private Industry 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Cynthia J. Bell . John D. McDonald 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1st Street Mt. Pleasant, Texas Cynthia J. Radcliff 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State permit. Pages 1
Department of Important: I 1/21/2012 Kalas Crematory Edgewater, Maryland Donation 5 Other Specify è 22 Name and Address of Facility George P. Kalas Funeral Home PA 21. Signature of Funeral Service Licenses 6160 Oxon Hill Rd. Oxon Hill, Maryland 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Atherosclerotic Cardiovascular Disease complicated Approximate Interval **Physician** Between Onset and /Medical Death a by Amyl Nitrite Use Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit Physician/Medical AMENDED 23a, 27, 28a-f, per me, g925 3-1-12 sm X UNPENDED P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of deliven 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Month Dav Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? é 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 🗸 Other: Scene ER/Outpatient 3 DOA 1 Yes No 28a. Date of Injury (Month. Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: Natural subject took drugs 1 Yes 2 X No 5 Pending fd 1-15-12 fd 09:26 am 2 X Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4651 Dallas P1.#102 Temple Hills,MD. 3 Could not be Suicide determined (Specify) Found:Residence Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Cal Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 2 🗸 and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E January 16, 2012 el 30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Pay State 25 Registrar

DHMH 17 Rev 1/2001

12-00430

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Ham Medical Facility Name (if not institution, give street and number) Town, or Location of Death 4b. City, 4c. County of Death Examiner timure Medica Baltimo If Under 1 Year If Unde 5. Social Security Number 8. Date of Birth .Sex 1¥⊡ M 2 □ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 2/11/1947 052-38-4228 New York 64 **Director** Usual Residence of Decedent or 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☐ No Md Ellicott City Howard 10e. Street and Number 10g. Citizen of What Country? or items 23a Funeral USA 738 Hollow Rd. 21043 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces þ 1 Never Married 2 X Married 1969-Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 XNo Specify: If Yes, Give Specify: "natural", Completed 3 Divorced 1973 Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene.

is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Deli Worker 4yrs Food Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William F. Mulvihill Muriel King permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dean C. Mulvihill/son 738 Hollow Rd. Ellicott City, Md. 21043 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 1/10/2012 Ardent Crematory Inc. Hanover, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc. 21. Signature of Fundal Service Licensee 4112 Old Columbia Pike Ellicott City, Md. 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician Nowischenic cardionyopat disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to lor as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed b 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform after death.

Director: After this certificate 2 No 2 🗌 No 1 Yes completed filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: XInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 X Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined within 24 hours a 29a. Certifie Xcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and the of certifier

Registrar

1+

30. Name and

31. Date filed (Month

no completed cause of death (Item 23a) (Type, Print)

Jezman MD

32.

Registral
DHMH 17 Rev 1/2001

OCME 2006

State

Ana Rubio MD.

Assistant Medical Examiner

32. Registr

900 W. Baltimore Street, Baltimore, MD 21223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend 26 per DVR G923 1/24/12 dk
State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2012 Constance January 2:02 Anne Martin Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Autumn Assisted Living Hagerstown Washington 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min Months Days Hours 1 □ M 2 🛣 F 220-28-3142 **Director** 77 Jan. 19, 1934 Maryland Usual Residence of Decedent or 28a-f show notified at 10a. State 10d. Inside City Limits 10c. City. Town or Location irector 1 Yes 2 X No Washington MD Hagerstown Ö 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? ō "natural", or items 23a o edical Examiner must be Funeral U.S.A. 21740 310 Cameo Dr. within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?

1 Yes 2 X No b 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates 3 X Widowed 4 Divorced White Completed is marked other than "natu aumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Domestic 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental 2 Marguerite Stull Page 1 and 2 should be ment of Health and Ments Wilbur Royce traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Department of Health Important: If item 27 any injury or other to once. Candice Uriarte/Daughter 1631 Woodlands Run, Hagerstown, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 K Burial 2 Cremation 3 Removal from State 1/18/2012 Rest Haven Cemetery 4 Donation 5 Other (Specify) Hagerstown, MD 21. Signature of Funeral Service Licensee Rest Haven Funeral Chapel 22. Name and Address of Facility 21742 1601 Pennsylvania Ave., Hagerstown, MD 23a. Part 1. Enter the disease, or compiler tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on expline. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Error Underlying Examiner Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last and burial-tran Due to (or as a consequence of): physician Physician/Medical that the death certificate be 68760 the use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Box (ō in the past 12 months? Day Month Pregnant at time of death Yes 2 No be detached the 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? q fo the Hospital or Attending Physician: The law requires osellus 1 Yes 2 No 3 Probably 4 Unknown Ś Completed should Record 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 autopsy has certificate 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital Be examiner? Other: 4 Nursing Home 5 Residence 6 M Other (Specify) Asst. Liv. Hospital: 1 🗌 Yes 2 Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural injury 5 Pending 1 Yes 2 No 24 hours after death. Funeral Director: A Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of My knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Fune

completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To tipe best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14 [1110 31. Date filed (Month Registrar's Signat State 2174 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 5:20A. Physician/ January 10, 2012 Thomas Erbin Martin Medical la. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Holy Cross Hospital Silver Spring If Under 1 Year | If Under 24 Hrs 7. Age (In yrs. last birthday) g. Birthplace (State or Foreign Social Security Number 8. Date of Birth **Funeral** 213-40-9860 Hours Feb. 11, 1942 Mary land 1 XM 2 □ F 69 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Director 1 🗆 Yes 2 🛣 No Silver Spring Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20906-1581 Funeral United States 14801 Pennfield Circle, #105 with death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12 Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 X Married by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. White If Yes, Give Year or Dates Specify: "natural", 3 Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene.

is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the University of Maryland Mail Supervisor Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ruby I. Easterling William M. Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other 14801 Pennfield Circle, #105 Silver Spring, MD 20906 Bonnie R. Aleshire Martin -wife 20a. Method of Disposition
1 ☐ Burial 2 A Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Metropolitan Crematory 1/11/2012 | Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Bornald Avers Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 onal 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Respiratory Failure disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Septic Shock Sequentially list conditions, Due to (or as a consequence of) Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Pneumonia that the death certificate be executed and -trar Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death the g Unknown ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed k þ End Stage Renal Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No has page 2 1 Yes 2 XNo certificate or Attending Physician: director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ this funeral 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No s after death.

I Director: After the ed in by the funeral 28d. Describe how injury occurred Certificate: iniury 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined within 24 hours a

To the Funeral C

completely filled To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D66249 January 10, 2012

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

JAN 2 3 2012

Jonathan Duran, M.D. HCH 1500 Forest Glen Road Silver Spring, Maryland 20910

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

62. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Nallev Rose M. January 2012 0616 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 148 Konrad Morgan Way Lothian Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🏝 F Months Days Hours Min. Apronto Day, 1934 Washington, Director 578-46-3210 77 Usual Residence of Decedent 23a or 28a-f show 10b. County the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Anne Arundel Lothian 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20711 USA 148 Konrad Morgan Way or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ò Maryland 21215-0036 White If Yes Give 1 Yes 2 No Specify: "natural", Specify: 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 72 ial Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Counselor 12 Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked of permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Stephen Rosetta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26325 Meadow Wood Drive Mechanicsville, MD Raymond Nalley (son) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Lincoln Cemetery 2012 Brentwood, MD 21. Signature Juneral Service Licensee 22. Name and Address of Facility Lee Funeral Home Calvert, Bary J. Goff 20736 8125 Southern Maryland Blvd. Owings, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cong Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence on that the death certificate be executed for use as the burial-transi Coronan that initiated events resulting in death) Last Due to (or as a consequence of physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day 1 Yes 2 I been signed by the should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires to within 24 hours after death.

To the Funeral Director: After this certificate has been sign. Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed 2 🗌 No 1 Tyes 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ျ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Medical Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural 5 \square Pending work? 1 ☐ Yes 2 Accident
3 Suicide
4 Homicide NA 2 🗌 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) SICINOS D0056936. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6502 KENILOORTH

dRW 4
Sta

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

RIVERDALE

MD

NAG ARAJAH, MD

32. Registra Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Januaru 3:01 pM Annette W. Novak 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Suburban Hospital Bethesda Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. **Funeral** Days 578-24-2149 **Director** 1 M 2 X F 85 May 23, 1926 Washington, DC Usual Residence of Decedent or 28a-f show 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director Bethesda 1 ☐ Yes 2X No Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? Funeral 20814 U.S.A. 5225 Pooks Hill Road, #512 North 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Yes 2 X No Completed by 1 Never Married 2 Married filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give White 3 X Widowed 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Industrial Products Executive Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Albert Wulf Miriam Luchs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sl Department of Health ar Important: If item 27 is any injury or other trau 7404 Mahaska Drive, Derwood, Maryland 20855 Audrey Suskind - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 X Removal from State King David Mem. Grdns. 01/08/2012 | Falls Church, Virginia 4 Denation 5 Other (Speciff) 21. Sign (ure | f Funeral service Lica 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 1800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Week Immediate Cause (Final Ph_sician/ Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 5 Months Hodgkin's Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 🗓 No Day Pregnant at time of death Unknown Month Year 1 ☐ Yes 2 🗷 9 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 K No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 1 No death? 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital nnette W. N မူ 2 **X** No 1 X Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify, funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of To the Hospital or Attending P within 24 hours after death.

To the Funeral Director; After the Completely filled in by the funera Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 06-2011

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.,

Paul Thambi.

31. Date filed (Month, Day,

JAN 06

D0061083

9707 Medical Center Drive, #300, Rockville, Maryland 20854

January 04, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 23a per med cert C924 2/1/12 dk
State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JANUARY 2012 7:30 P M SYLVIA JEAN BROWN NORRIS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **CHARLES** RESIDENCE. 7011 HEATHER DRIVE BRYANS ROAD 8. Date of Birth (Month, Day, Year) MAY 4, 1945 7. Age (In vrs. last birthday, If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Funeral NORTH CAROLINA **Director** 246-66-4089 1 □ M 2 🕱 F 66 Yrs. Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 No MARYLAND CHARLES BRYANS ROAD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 7011 HEATHER DRIVE 20616 UNITED STATES 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? 1 X Never Married 2 Married þ ☐ Yes Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: If Yes, Give Year or Dates Specify: BLACK Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. 2 YEARS Elementary/Secondary (0-12) SECRETARY FEDERAL GOVERNMENT Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) t. Page 1 and 2 should be fill thent of Health and Mental tant: If item 27 is marked or ဂ HENRY TOM BROWN FANNIE MAE CARMON BROWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MATOKA D. NORRIS / DAUGHTER 7011 HEATHER DRIVE, BRYANS ROAD, MARYLAND 20616 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1X Burial 2 Cremation 3 Removal from State RESURRECTION CEMETERY JAN. 14, 2012 CLINTON, MARYLAND 4 Donation 5 Other (Specify) Signature of Funeral Service I Cense JOHNSON MOO583 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 LYDIA C. THORNTON 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph√si∟ian/ Choon, disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence on) Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Box (3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has page 2 performed? Yes 2 XN To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) **Division of Vital** Certificate: To Be Other: 4 Nursing Home 5X Residence 6 Other (Specify) 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA after death. Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a To the Funeral L Medical X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific 29d. Date signed (Month, Day, Year,

Registrar

DHMH 17 Rev 06-2011

State

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

2012

31. Date filed (Month, Day, Year)

JAN 10

Funeral Months Days Hours (Month, Day, Year) 189-10-8102 Director 1 X M 2 □ F Yrs Oct. 12, 1918 Usual Residence of Decede 28a-f show 10a. State 10b. County ms 23a or 28a-f sho must be notified at 10c. City, Town or Location Director MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1505 Gleason Street 20902 USA hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iterr edical Examiner r 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. þ 1 Never Married 2 Married 2 No Maryland 21215-0036 Specify:White If Yes, Give Year or Dates. 1944-47 1 Yes 2 X No Specify: Completed 3 Divorced 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Meaonee. other than life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Manager Retail Store Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည Joseph Ogurchak Anna Melinche 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nora Terrill Ogurchak/Wife 1505 Gleason Street, Silver Spring, MD 20902 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Jan. 4 ☐ Donation 5 ☐ Other (Specify) Rockville, MD Parklawn Memorial Park 2012 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Cardiorenic Shock disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Acute Myocardial Infarction Sequentially list on Ultimating if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) for use as the bur Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 8-12 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No been signed by the a should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? WRCHA 24a Was an or Attending Physician: The law has page 2 performed Yes 2 certificate Vital the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2x No မ 1 Yes 1 X Inpatient 2 ER/Outpatient 3 DOA this U 28a. Date of injury (Month, Day, Year) of 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred After 0 1X☐ Natural 5 \square Pending Division M Accident Investigation within 24 hours after deatl To the Funeral Director. 6 Could not be Suicide MICHAEL 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are begible State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

4b. City, Town, or Location of Death

If Under 1 Year If Under 24 Hrs.

Bethesda

2. Date of Death

January

8. Date of Birth

3 2012

4c. County of Death

Montgomery

PA

8,

3. Time of Death

5:48

9. Birthplace (State or Foreign

10d. Inside City Limits

1 Yes 2 No

MD 20901

Year

Onset and Death

Month

29d. Date signed (Month, Day, Year, January 9, 2012

Day

1 Yes 2 No

1	O	r.j.	

p M

DHMH 17 Rev 06-2011

State Registrar

completely

To the

(Check

only one

29b. Signature and

3 [

Peter J. Sabia, MD

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

For State Registrar

Michael

Social Security Number

Physician/

Examiner

Medical

. Decedent's Name (First, Middle, Last,

Suburban Hospital

Francis

4a. Facility Name (if not institution, give street and number)

0gurchak

7. Age (In vrs. last birthday)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

40365

1400 Forest Glen Road, #200, Silver Spring, MD 20910

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2347PM lanuar JOSEPH H. POWELL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S HOSPITAL DOCTORS COMMUNITY LANHAM If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthdav. **Funeral** Hours Director 214-30-0901 1 🔀 M 2 🗆 F 78 May 17, 1933 show or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Prince George's Springdale 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō d Mental Hygiene. marked other than "natural", or items 23a o matic event, the Medical Examiner must be Funeral 20774 9415 Stoney Ridge RD IIS 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. by 1 Never Married 2 Married 1 Yes 2 X No Burell, Joseph Baltimore, Maryland 21215-0036 **Black** 1 ☐ Yes 2 🛣 No Specify. Specify: 3 → Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Truck Driver Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ injury or other traumatic Francis Snowden Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9415 Stoney Ridge RD, Springdale, MD 20774 Sheila Moody/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or of once. 1 🖾 Burial 2 🗆 Cremation 3 🗀 Removal from State Washington, DC 1/10/2012 4 Donation 5 Other (Spec Mt. Olivet Cemetery 22. Name and Address of Facility Pope Funeral Homes, P.A. ur of Funeral Service L 5538 Marlboro Pike, Forestville, MD 20747 Part 1. Enter the disease or complications shock, or heart failure. List only one cause that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Ph_sician/ CAMPIOMYONA Medical resulting in death) Examiner Secure tighty list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): nding physician Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death2 þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an death?
1 Yes 2 No Yes 2 No I or Attending Physician: after death.

Director, After this certification funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 🗌 Yes 1 Inpatient 2 MER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manne Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred **₩**Natural 5 Pending Accident 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral I

completely filled Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Ceptifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one re and Me of certifie 29b. Signa 29d. Date signed (Month, Day, Year) 7226 Name and address of person who completed cause of death (Item 23a) (Type, Print) 8116 God lock Nd M 32. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 - State Registra 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2012^{Year} January 8:50AM Physician/ Dorothy Estelle Pinto Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Prince Georges Clinton Southern Maryland Hospital Birthplace (State or Foreign Country) 8. Date of Birth If Under 24 Hrs. If Under 1 Year 7. Age (In yrs. last birthday) (Month, Day, Year) Social Security Number Months **Funeral** Maryland 578-22-3123 89 Sept. 6, 1922 1 □ M 2**XX** F Yrs **Director** Usual Residence of Decede 10d. Inside City Limits 10c. City, Town or Location 10b. County 23a or 28a-f show 10a. State event, the Medical Examiner must be notified at with the Maryland Director 1 Yes 2 X No North Carolina Calabash Brunswick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A Funeral 28467 397 Oconee St. NW Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, or items 12. Was Decedent Ever in U.S. Armed Forces? be filed within 72 hours after death Black, White, etc. 11. Marital Status Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Specify: White 1 Yes 2 No Baltimore, Maryland 21215-0036 "natural", 3XX Widowed 4 Divorced Year or Dates 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Mollie Barrett ပ George Harrison Day injury or other traumatic 1 and 2 should be the Health and Meritem 27 is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 397 Oconee St. NW Calabash, NC 28467 Josephine Rivera (Daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date January 20, 2012 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Cheltenham, MD MD Veteran's Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc. 21. Signature of Funeral Service Licenses MO1555 6633 Old Alexandria Ferry Rd. Clinton, MD 20735 rate 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, so ck, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Due to (or as a consequence of): resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine Hospital or Attending Physician; The law requires that the death certificate be executed ing physician and as the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy nse 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) Pregnant at time of death 1 ☐ Yes ∠ v 9 ☐ Unknown Unknown been signed by the a should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N after death. Director: After this certificate has I 2 🗌 No 1 🗌 Yes 26. Place of Death (Check only one) 25. Was case referred to medical completely filled in by the funeral director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 No 은 28d. Describe how injury occurred 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: iniury 5 Pending 1 🔀 Natural Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hours a To the Funeral L Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 3 [29d. Date signed (Month, 29b. Signature and title of certifier

State Registrar Registrar's Signature

Day, Year,

2012

12-00083 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Quan Thahn Phan State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2. Date of Death Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ 1317 hrs January 3, 2012 Medical Examiner Quan Thanh Phan Ouan Thahn Phan c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Charles Indian Head Rear of Rivers Edge Terrace If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** oreign vietnam Min. Months Days Hours Director 1945 pril 10. 537-33-4757 1X M 2 F 66 Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location E S 10b. County 1 Yes 2XX No 28a-f sho₩ 123a or 28a-f show e notified at once. permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner was be matter. Maryland Prince Georges Indian Head irector 10g. Citizen of What Country? 10f. Zip Code 17 Rivers Edge Terrace 20640 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 11 Marital Status White etc. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Yes 2 X No 1 Yes 2 No specify: Specify: Asian 4 Divorced If Yes, Give Year 3 Widowed 2 16a. Decedent's Usual Occupation (Give kind of work done 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Farming 12th. Farmer 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Huong Phan

19a. Informant's Name/Relationship (Type, Print) <u>Nhi Thi Nauven</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rivers Edge Terrace Indian Head, MD. Cuc Tran/ Wife 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Burial 2 X Cremation 3 Removal from State crematory or other place) Jan. 10, 20<mark>1</mark>2 Waldorf, <u>Maryland</u> Huntt Crematory Donation 5 Other Specify: Signature of Funeral Service Licenses 22. Name and Address of Facility Huntt Funeral Home 3035 Old Washington Rd. Waldorf, MD. 20601 Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line Medical Death Atherosclerotic cardiovascular disease complicated by Immediate Cause (Final disease *È*xaminer or condition resulting in death) Due to (or as a consequence of): hypothermia Sequentially list conditions. Due to for as a consequence off-Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed and x AMENDED 1 per me g924 2-2-12 yt 23a, PII, 27, 28a f, per ME g923. 1/27/12 TRT Physician/Medical X UNPENDED signed by the attending physician be detached for use as the burial -Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the 2 Fetal death Year Live birth 3 Ectopic pregnancy Month Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ò 1 Yes 2 No 3 Probably 4 V Unknown Diabetes mellitus Completed After this certificate has been submeral director, page 2 should 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No the Hospital or Attending Physician: hin 24 hours after death, 26.Place of Death (Check only one) 25. Was case referred to medical æ Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 Other: Scene ER/Outpatient 3 DOA 1 Yes 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27 Manner of Death 28d Describe how injury occurred to cold Certification: within 24 hours after deam.

To the Funeral Director: A Natural 1 Yes 2 X No 5 Pending Fd 1/3/12 FD 1:17 pm environment 2 X Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) (rear of) Rivers Edge Ter Indian HEad MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 6 Could not be (Specify) Fd: swampy area Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner

201 32. Registrar's Signature

Ling Li, MD

31. Date filed (Month, Dat Year)

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

January 4, 2012

1 - For State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 8:00 AM Medical Facility Name (if not institution, give County of Death 4b. City, Town, or Location of Death **Examiner** exinator Year Monder 24 Hrs. 9. Birthplace Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, (State or Foreign Funeral Months Hours 1 □ M 2X F 95 MD **Director** 26 577 122 /16/1916 Usual Residence of Decedent Show 10d. Inside City Limits 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County Director 1 √ Yes 2 □ No Mary's MD St. Lexington Park 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 21412 Great Mills Road 20653 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Armed Forces Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: Specify: Black 3 ₩idowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) St.Mary's Public Elementary/Seconday (0-12) College (1-4 or 5+) Schools Custodian 7th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Veronica Fenwick Ambrose Lewis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sylvia Rothwell/Grand-Daug Willow Rd. Lexington Park MD 20653 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/10/2012 Lexington Park, MD Immac.Heart Cem. 21. Signature of Funeral Service License 22. Name and Address of Facility Briscoe-Tonic Funeral Home Brett Way Mechanicsville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Prysician disease or condition resulting in death) Medical Due to or as a consequence of) Examiner ANCED Securitielly list conditions Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury attending physician and for use as the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant 9 Unknown Pregnant at time of death been signed by the should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 3 Probably 4 Unknown 1 Yes 2 No Records. Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death. To the Funeral Director: After this certificate has k autopsy performed 1 ☐ Yes 2 ☐ No 2 X No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Division of Vital funeral director, Be Hospital 1 Yes 2 X No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 Yes 2 No Investigation
6 Could not be Accident completed filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who comp leted cause of death (Item 23a) (Type, Print) GREATMINS Rd. LOWING HOWIFF, Md 20653 .FRAMANCRAP (Month, Day, Year) 32. Registrar's Signature AN 0 6 201 Registrar

12-00011 Fric Pannell Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ric Pannell		1- For State	tate of Marylar		artment of <i>rtificate of</i>		Mental H	ygiene	201	2 0176		
Physicia		Registrar 1. Decedent's Name (First, Midd	ile,Last)			Deam		2. Date of Deat		3. Time of Death		
Medical Exami		ERIC ROLAND PA	NNELL					Month January 1,	Day Year 2012	0955 hrs		
)		4a. Facility Name (if not instituti Atlantic General Hos		ber)		4b. City, Town, or I Berlin	ocation of Death	1	4c. County of De Worcester	ath		
Funeral Director		5. Social Security Number 217-96-9426	6. Sex 7.	. Age (In yrs. I	last birthday) Yrs	If Under 1 Year Months Days	If Under 24Hrs Hours Min	_	Birthplace (State or reign Country)			
		Usual Residence of Decedent				<u> </u>		03/22/				
w апу		10a. State 10b. County			, Town or Locat	ion				10d. Inside City Limits 1 XYes 2 No		
Aaryland 28a-f show 1 at once.	ctor	MD Frede 10e. Street and Number	rick	Fre	ederick	10f. Zip Code		10	ng. Citizen of What C			
he Mau 1 or 28	Director	6705 Sandpiper	Court			21703			USA			
MD 21215-0036 d 2 should be filed within 72 hours after death with the Maryland thand Mental Hygiene. n 27 is marked other than "natural", or items 23a or 28a-f sho numatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2	12. Was Deced			s Decedent of Hisp es, specify Cuban,				nerican Indian, Black,		
er deat			vorced If Yes, Give Year	2 No		Yes 2 X No		, , , , , , , , , , , , , , , , , , , ,				
2 hours aft "natural" Examine	d by	15. Decedent's Education (Spe			16a. Deceden	t's Usual Occupation	on (Give kind of		Specify: B1 16b. Kind of Busines			
5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examiner	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)	_	ost of working life.		ired)				
5-0036 led within 72 Hygiene. other than	dmo	12th 17, Father's Name (First, Middle) Last\		Tow Ti	ruck Driv		/First Middle N	Werking Maiden Surname)	Towing		
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than	Be C		Roland Nathan Pannell Faye Gray									
Baltimore, MD 21215 permit. Pages I and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked o	၉	19a. Informant's Name/Relation			4.1	•						
md 2 sl and 2 sl salth ar		Faye Pannell/m	other	1 20h		Jeremy T		Derwood	2, MD 2085			
Baltimore, MD permit. Pages I and 2 she Department of Health and Important: If item 27 is injury or other traumati		1 X Burial 2 Cremation		n State	crematory or oth	ner place)						
Iltim nit. Pa artmen ortant		4 Donation 5 Other S 21. Signature of Funeral Service	pecify.	Gat	22. N	eaven Cen	of Facility Sp	/06/2014 <i>Owi</i> den Fi	neral Hom	Spring, MD		
Per Per Juli	1.39	Denge	Anna	edens	1 240	N. Wash	ington	St, Rock	ville, MD			
Physician Modical	ĺ	23a. Part I. Enter the disease, o failure. List only one cause	r com plic ations that cau on each line.	sed the death	. Do not enter th	ne mode of dying, s	such as cardiac o	or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and		
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Atherosclero			Death						
		Sequentially list conditions,	b	311304001100 0								
	iner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a co	onsequence o	of):							
ecuted 1 and consist	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a co	onsequence o	of);							
so, te be executed ysician and burial - transit	edical	UNPENDED	AMENDED									
x 6876 n certificat ending ph use as the	- ΣΙ	IF FEMALE: 23b. Was decedent pregnant in topast 12 months?	4 Pregnar	h nt at time of de	2 Fe	tal death 3 [Ectopic pregna	ancy	23d. Date of deliv Month	rery Day Year		
D.O. BO) that the deatl ned by the att detached for	Phys	Part II. Other significant condi	9 Unknow		esulting in the u	inderlying cause gi	ven in Part I.	23e. Did to	bacco use contribute	to the cause of death?		
ires that the signed by	Š		•					1 Yes	2 No 3 P	robably 4 🗹 Unknown		
ords, w requires to should	ompleted						-	24a. Was a autops	sy prior t	autopsy findings available to completion of cause of		
Reco	E OS							perform 1 ✓ Yes 2				
Vital Rec ysician: The his certificate director, page	Be	25. Was case referred to medica examiner?	elle-seitel.		EDIO . III I		of Death (Check		2 :1 2 2 2			
ing Physical After this funeral dir	٤	1 Yes 2 No 27. Manner of Death	28a. Date of	Injury	ER/Outpatient 28b. Time of I	0 00,1	/ at Work?	ng Home 5 1	Residence 6 Ot	her:		
ion (tending eath. tor: Af	Ę		(Month, D	ay,Year)		1 Y	es 2 No					
Divisi pital or Att ours after de neral Direct filled in by	Certification:	3 Suicide 6 Cou	28e. Place of (Specify)	of Injury - At he	ome, farm, stree	t, factory, office bu	uilding, etc.	28f. Location (S or Town, St		Rural Route Number, City		
Division To the Hospital or Attent within 24 hours after death within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 CertifyIng P	Physician: To the best of arminer: On the basis of and manner state	examination a	ge, death occur ind/or investigat	red at the time, dat ion, in my opinion,	e and place, and death occurred a	I due to the cause at the time, date a	e(s) and manner as s and place, and due to	tated. the cause(s)		
- 3	Me	29b. Signature and title of certifi		-		29c. License			29d. Date signed (I			
		+ a	1. 1t	-		O.C.N	1.E.		January 2, 201	2		
		30. Name and address of person who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223										
St Regist	ate	31. Date filed (Month, Day Year)	2012 32 Regi	strar's Signatu	bar	2.0						

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and P.O. Box 68760 signed by the a Records, Division of Vital

Baltimore, Maryland 21215-0036

if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last	c. Due to (or as a consequence of): d											
FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown 23c. If yes, outcome of pregnancy 23d. Date of delivery 23d. Date of delivery Month Date of death 5 Other (specify) Month Month												
Part II. Other significant conditions co	ontributing to death but not resulting in the underlying cau	use given în Part I.	23e. Did tobacco u		cause of death?							
			24a. Was an autopsy performed?	prior to com death?	sy findings available pletion of cause of							
25. Was case referred to medical	26. Place of Death (Check only one)											
examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	5 🔀 Residence 6	Residence 6 Other (Specify)									
27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident Investigation	(Month, Day, Year) injury M	Injury at work? 1 Yes 2 No	28d. Describe how injury occurred									
3 ☐ Sulcide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, o building, etc. (Specify)	office 28f	28f. Location (Street and Number or Rural Route Number, City or Town, State)									
(Check 2 Medical Examin	sician: To the best of my knowledge, death occurred at the ner: On the basis of examination and/or investigation, in my see Practitioner: To the best of my knowledge, death occurred.	opinion, death occurred at the	e time, date and place,	, and due to the caus	se(s) and manner stated							

29c. License number

D37142

29d. Date signed (Month, Day, Year) January 9,2012

Rockville, MD 20855

State

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year,

G. Coleman M.D.

JAN 1 0 201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

#32. Registrar's Signature

6001 Muncaster Mill Rd.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = For State Registr/MEND#1per/MD, 1/11/12; BMW, McCo Certificate of Death APPROPRIES NEED FINE MICH TO BE THE 2. Date of Death Pacholkiw 3. Time of Death Physician/ 2012 11:45 PM Elisabeth Pacholkiw January Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery Social Security Number Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, **Funeral** Months Days Hours Min (Month, Day, Year) 577-46-3974 **Director** 1 M 2 F 91 Vrs May 9, 1920 Usual Residence of Decedent Germany show 10a. State 10b. County 10d. Inside City Limits the Maryland 10c. City. Town or Location notified at Director 28a-f 1 Yes XX No MD P.G. Bowie 10e. Street and Number 10f. Zin Code ö 10g, Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be Funeral 16010 Excalibur Road, Apt. D106 20716 USA Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 11 Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2XXNo Specify: If Yes, Give Year or Dates 3 🖺 Widowed 4 🗌 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Cook Food Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ဂ Anton Blechschmidt other traumatic Maria Ehm 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a item 27 i Charles Pacholkiw/Son 4532 Middleton Lane, Bethesda, MD 20814 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of H Important: If ite any injury or oth 1 X Burial 2 Cremation 3 Removal from State Jan. 13, 2012 Fort Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. Francis J. Collins Funeral I 500 University Blvd. W., Si. 23a. Part, Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 500 University Blvd. W., Silver Spring MD 20901 Approximate Interval Between
Onset and Death neumonia Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) ria Errapsit that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician d be detached for الكم عم المناطقة 01/06/2012 et 1145 pm Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav 5 Other (specify) Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown director, page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\text{Yes} \) 2 \(\text{No} \) No 24a. Was an autopsy has After this certificate Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital Other: ျ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) stely filled in by the funeral 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c, Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After injury 1 Natural 5 Pending AMMA Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) (2 D37891 January 7, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Amit Rajvanshi, MD 121 Congressional Lane, #409, Rockville, MD 20852

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year) **JAN 1** 0 2012

32. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Reg. No. Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month 2012 Medical Josephine Betty Pearl 7:30 January 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Hillhaven Nursing Home <u>Adelphi</u> Montgomery Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth Social Security Number **Funeral** Months Days Min Hours Director 301-22-2732 1 M 2 X F 90 06/24/1921 Ohio Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Yes 2 X No Prince George Marvland Mount Rainier ò 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 3409 Eastern Avenue items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Deceded... Armed Forces? - ☐ Yes 2 🔀 No 14. Race - American Indian, the Medical Examiner Black, White, etc. ö 1 Never Married 2 Married þ Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White "natural" 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Domestic event, Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ည Department of Health and Ment: Important: If item 27 is marked any injury or conpe Unknown Elizabeth Snedden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8627 Cunningham Dr. College Park, MD 20740 Daria Reamy/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 01/12/2012 Brentwood, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Fort Lincoln Funeral Home ne 3401 Bladensburg Rd. Brentwood, MD 20722 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) cause. Enter underlying use as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregna 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ρ in the past 12 mor Month Day Year Yes $2 \square N$ detached the P.O. yd bar 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 3 Probably 4 Unknown Records, 1 Yes 2 1 Completed been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page, performed? certificate Yes 2 No Yes 2 Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director; After this certific 25. Was case referred to medica funeral director, Be 26. Place of Death (Check only examiner's Other 1 Yes 2 [ပ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Manner of 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred N ral ccident (Month, Day, Year) 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation filled in by the 6 🗌 Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 To the I Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and tit of ce 29c. Lices death (Item 23a) (Type, Print) 30. Name and ac

DHMH 17 Flov 06 2011

State Registrar 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 7:00 A M **Physician** VELYN -12 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BROOKLYN PARK ANNE ARUNDE GENESIS, HAMMONDS If Under 24 Hrs. If Under 1 Year Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Hours Min. 1□M 2▼F MARILAND Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County . 10c. City, Town or Location show ed other than "natural", or items 23a or 28a-f showevent, the Medical Examiner must be notified at 1 ☐Yes 2 No Director HALETHORPE BALTIMORE TD. 10e. Street and Number 10g. Citizen of What Country? 21227 2015 SMITH AVE. 1.5.A by Funeral filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐Yes 2 No Specify: 3 ₩idowed 4 Divorced WhITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) nd Mental Hygiene. marked other than tomemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event Be LOUIS STEIN ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2015 Smith AVE. HALETHORPE, MD. 21227 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 1-21-12 ODENTON, M.D. 4 ☐ Donation 5 ☐ Other (Specify) of Figeral herty funeral Home M00942 2601 MOUNTAIN RD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirate shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ongest disease or condition resulting in death)) /Medical Due to (or as (consequence of): Examiner Sequentially list conditions, any loading termination cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner burial-trans resulting in death) Last Due to (or as a consequence of): physician sthe burial Box 68760, The law requires that the death certificate be Physician/Medical as IF FEMALE: nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregrant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy jo in the past 12 mg/ Month Day 5 ☐ Other (specify) signed by the a Ö 1 □Yes 2 🗖 No 9 Unknown ۵. to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform certificate 1 ☐Yes 21 2 No al or Attending Physician: safter death.
Il Director: After this certifica of in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner eath 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 1 atural 5 ☐ Pending investigation 1 □ Yes 2 🗆 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined completely filled in by 4 Homicide within 24 hours a To the Funeral C To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 0 50 725 29d. Date signed (Month, Day, Year) Stonatur Name and address of person who completed cause of death (Item 23a) (Type, Print) ViatorBIN GlenBurnie 693C Year) 31. Date filed (Month, Day, Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Eugene Charles Rehkemper January 2012 10:30 A.M Medical 4a. Facility Name (if not institution, give street and number, 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Chesapeake Beach 3916 Street Calvert 14th If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Numbe 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F 01/10/1947 Newfoundland **Director** 219-46-6474 64 Usual Residence of Decedent 28a-f shov 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic and any injury or other traumatic 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Calvert Chesapeake Beach 10e. Street and Number 10g. Citizen of What Country? Funeral 3916 14th Street 20732 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 central office technician telephone company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ George Rehkemper Helena Mary Beyers 19a. Informant's Name/Relationship (Type, Print, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elsie B. Rehkemper, spouse 14th St., Chesapeake Beach, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) St. John Vianney Cem. 01/07/2012 | Prince Frederick, MD Signature Funeral Service Licens 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD uba 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ CARDIAC disease or condition resulting in death) ARRYTHMIA Medical Due to (or as a consequence of) Examiner HYPERTENSION Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Exami Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trai Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 ending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d Date of delivery 1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown signed by the atte Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ DIABETES 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical the funeral director Be 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 🗶 No Hospital: Other: 유 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) After t Certificate: 28c. Injury at work? 28d. Describe how injury occurred injury 1 X Natural 5 Pending s after death. 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation within 24 hours after de To the Funeral Directo completed filled in by th 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number D40370 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Wisniewski M.D. Peter L. 110 Hospital Rd. #310, Prince Frederick, MD 20678 32. Registra State

DHMH 17 Rev 7/2009

Registrar

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	Examin	er	4a. Facility Name (if not institution, give si Suburban Hospita)				4b. City, Town, o	r Location of Dea la	th	4c. County of Death Montgomery				
Ī	Funeral Director		5. Social Security Surger 6. Sex 579–02– 8855 1 🕅	7. Age 7. Age 7. 7.3	(In yrs. last bir	thday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr. Hours Min				Birthpla	ce (State or Foreign	
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Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	d be filed widental Hygis rked other tic event, t	To Be (17. Father's Name (First, Middle, Last) Bel Kassem Rouag			500		18. Mother's Na Saadia	me (First, Middle Rouag					_
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more, Page 1 an nent of He ant: If item			20a. Method of Disposition 1 ☑ Burjal 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	cemete	ry, cren	sition (Name of latory or other place n Cemeter		Date 1/2012		ocation - City Zerea		^{n, St} Atlgeria gers,	
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Licens	Mun		J:	Name and Addre Anazah Se 4640 Flir	ss of Facility ervices at Lee R	d. Suite	С.	Chanti	11y	, VA 2015	1
			23a. Part 1. Enter the disease, or compli shock, or heart failure. List only one	cations that caused cause on each line.	the death. Do r	not ente	r the mode of dyin	ng, such as cardia	c or respiratory a	rrest,		l b	Approximate Interval Between	Ī
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Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be explained to the contribute of th	by Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of 1 Live Birth 2 4 Pregnant at 9 Unknown	2 🗌 Fetal deatl		Ectopic pregnand Other (specify)	су			23d. Date of Month	,	ay Year	
P.0	s that t gned by e deta	by PI	Part II. Other significant conditions con	tributing to death bu	it not resulting	in the u	nderlying cause gi	ven in Part I.					cause of death?	
rds,	equires een siç ould b	ted	Esophageal Cancer						1 🗆	Yes 2	2 № 3 □	Proba	bly 4 🗌 Unknowr	١
io Se	has be	Completed							24a. Was	psy	prior t	o com	y findings available pletion of cause of	
ř	sician: The law r certificate has b irector, page 2 sl		25. Was case referred to medical				26 PI	lace of Death (Che		ormed? 2 🔼 N	lo 1 🗆 Y	res 2	□ No	_
ZĮ	nysicia nis cert direct	To Be	examiner? 1 XX Yes 2 No	ospital: 1 🔀 Inpatie	nt 2 🗆 ER/Ou	utpatien		er:	Home 5 Res	idence	6 ☐ Other (Sp	ecify)		
on of	ending Pl sath. or: After the	Certificate:	27. Manner of Death 1 □ Natural 5 □ Pending 2 ☒ Accident Investigation	28a. Date of injury (Month, Day, 12/19/11	Year) 28b.	Time of njury	28c. Injur	yat ⟨? Yes 2 ⊠ No	28d. Describe Peg Pl		•			
DIVIS	salor Att salerd al Direct		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injurbuilding, etc. Suburba	y - At home, fa <i>(Specify)</i> n Hospi	rm, stre	et, factory, office	tory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) Bethesda, MD					oute Number,	
	to the Hospital or Attending Physician: In this 24 hours are dealers are the funded by the funderal Director. After this certific completed filled in by the funeral director.	Medical	29a. Certifier (Check only one) 1 X Certifying Physic 2 Medical Examine 3 Certifying Nurse	er: On the basis of ex	amination and/o	or invest	gation, in my opinio	on, death occurred	at the time, date	and plac	e, and due to the	e cause	e(s) and manner state	ed.
D	2		29b. Signature and title of certifier	1	D		29c. License D516				ate signed (M o. 5 , 2			
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nelson Kalil, M.D. 5454 Wisconsin Ave. #1300 Cnevy C								Chase, MD 20815				

State Registrar Nelson Kalil, M.D.

31. Date filed (Month, Day, Year)

JAN 0 6 2012

32/Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician/ 2012 9:00 January Anne McTaggart Rinehart Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 419 Third Street Anne Arundel Annapolis If Under 8. Date of Birth (Month, Day, Yea 7/4/1929 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral Months Hours Min 1 🗆 M 2 😾 F **Director** Maryland 214-24-9521 82 Yrs Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a, State Director Maryland Anne Arundel Annapolis 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 419 Third Street 21403 USA death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 hours after White 1 Yes 2 No Specify: If Yes, Give Specify: Completed 3 ¥ Widowed 4 ☐ Divorced Year or Dates injury or other traumatic event, the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) County Government Accountant Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Emma Florence Petersen Daniel Joseph McTaggart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Laura VanHook - Daughter 3714 3rd Ave, Edgewater, MD 21037 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🗌 Burial 2 🙀 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory 1/4/2012 Baltimore, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MAG LANCER disease or condition resulting in death) Medical Due to (or as a c sequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). Examin Cause (Disease or Injury that initiated events resulting in death) Last that the death certificate be executed Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death the been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown To the Hospital or Attending Physician: The law requires Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy is certificate h Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 Tes 2 No 2 1 Inpatient 2 ER/Outpatient 3 IDOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After of the funer iniury 5 Pending Natural Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only or 29b. Signat 29c. License number 29d. Date signed (Month, Day, Year)

State

Registrar

completed cause of death (Item 23a) (Type Mesk. 31. Date filed (Month)

Name and address of person who

Print)

0112715

1/3/12

210 DAMOND MO 21401

5,

1924

2012

4c. County of Death

10g. Citizen of What Country?

Specify:

16b. Kind of Business/Industry

Retail

20c. Location - City or Town, State

Winfield, MD

23d. Date of delivery

Day

3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Year

Month

23e. Did tobacco use contribute to the cause of death?

2 X No

1 □ Yes

28d. Describe how injury occurred

24a. Was an autopsy performed?

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one

USA

14. Race - American Indian Black, White, etc.

white

Frederick

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Oneet and Death

1 Yes 2 No

Massachusetts

1 - For State Registrar 1. Decedent's Name (First, Middle, Last) **Physician** Gerard J. Robertson, Sr. January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** St. Joseph's Ministries Emmitsburg If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 M 2 □ F Feb 25. 87 Director 025-16-6194 Usual Residence of Decedent 10c. City, Town or Location 28a-f show ed other than "natural", or items 23a or 28a-f shovevent, the Medical Examirer must be notitied at Emmitsburg Directo Maryland Frederick 10f. Zip Code 10e. Street and Number 21727 331 S. Seton Ave Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 11 Marital Status Was Decedent Ever in U.S Armed Forces? 1 Myes 2 □ No If Yes, Give Year or Dates: WWII filed within 72 hours after 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 □Yes 2 No ò 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Pages 1 and 2 should be filed withir nent of Health and Mental Hygiene. int: If item 27 Is marked other than Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marie Goetz Daniel Robertson ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2628 Gull Way, unit 102, Ocean City, MD 21842 Pamela Sanders, daughter 20b. Place of Disposition (Name of carnetery prematory or other place) Date 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/06/2012 Carroll Crematory 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Myers-Durboraw Funeral Home R. 210 W Main St, Emmitsburg, MD 21727 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause of each ine. of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physiclan; The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) 1 □Yes 2 □No ed by the detached 9 Unknown 9 Unknown 2 After this certificate has been s funeral director, page 2 should

Completed Be 1 Yes 2 No Certification: To 27. Manner of Death 1 Natural
2 Accident 3 Suicide 4 Homicide

29a. Certifier

(Check only one)

25. Was case referred to medical examiner? Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year)

and manner stated.

5 Pending investigation 6 ☐ Could not be

310

1 □Yes 2 □ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28c. Injury at (Work?

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number 29b. Signature and Mile Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. Seton

Emmitsburg

29d. Date signed (Month, Day, Year)

arroll 31. Date filed (Month, Day, Year)

JAN 0 6

32. Redistrar's Signature

State Registrar

Medical

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ John Marshall Randle <u>January</u> 2012 10:40 a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Keymar 738 Francis Scott Key Hwy If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) NOV 19, 1958 9. Birthplace (State or Foreign Social Security Number Age (In yrs. last birthday, **Funeral** Days 1 XM 2 🗆 F Months Hours Mary land Director Nov 53 216-72-0331 Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits within 72 hours after death with the Maryland at 10c. City, Town or Location Director artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sl injury or other traumatic event, the Medical Examiner must be notified i Maryland Carroll Keymar 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21757 738 Francis Scott Key Hwy USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 X Yes 2 No 1976If Yes, Give Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 Widowed 4 Divorced white Completed 1978 Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Bathroom Tile Self Employed 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic even ones. ည Lethia Mae Tyler Van Craiq Randle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 738 Francis Scott Key Hwy, Keymar, MD 21757 Virginia Randle, wife 20b. Place of Disposition (Name of care place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 1/6/2012 Winfield, MD 4 ☐ Donation 5 ☐ Other (Specify) Carroll Crematory 22. Name and Address of Facility Myers-Durboraw Funeral Home Signature of Funeral Service Licenses SANDE 136 E Baltimore St, Taneytown, MD 21787 Litar Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a conse uence of) **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events KLEPa resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: Live Birth 2 Fetal death yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) the 9 Unknown ρ signed I Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 No has prior to completion of cause of death? certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 \sum Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director. After this completed filled in by the funeral director. 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Yes 2 No М Accident Investigation Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier WJL me and address of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addres 21703 PIKE FREDERKK 1564 DPOSSUMTOWN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

JAN 0 6 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Rider Lee 1725 Norman 2012 01 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Nursing + Rehab. Center Anchorage Salisbur Wicomico If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 M 2 D F Hours (Month, Day, **Director** 219-42-8180 Mary Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No Princess Maryland Somerset 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a Completed by Funeral Ridge 21853 29169 U.S.A 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify Specify: Black "natural", 3 Divorced traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) Clear Channel Artist 12th grade year coiles Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Catherine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rider 29169 Rd. Helen Princess Anne, MD, 21853 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Important: If cemetery, crematory or other place Princess Anne, MU 1/11/12 Church Cemeters 21. Signature of Funeral Service Licensee Anthony E. ward F. H. 30639 Ave Princess Anne, MA, 21853 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician CEREBRO VASCULAR disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner HYPERTENSION Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed use as the bunal-transi Cause (Disease or linjury DIABETES MELLITUS. and that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant : 9 Unknown Month Day Year Pregnant at time of death 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 🗋 No 3 🗎 Probably 4 🗹 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has completed filled in by the funeral director, page 2 autopsy performed? 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death, Check only one) Hospital 2 No Other: 1 Tyes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28c. Injury at work? **₩** Natural 5 Pending 1 Yes 2 No hours after death Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 71972 9 2012 1415 S. DIVISION 30. Name erson who completed cause of death (Item 23a) (Type, Print) STREET SALISBURY, MD-31. Date filed (Month State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ LORNA REED Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death NICOMIC pice at the 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Hours Director 214-28-5675 1 M 2 X F 90 06/09/1921 Australia Usual Residence of Decedent Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, <u>the M</u>edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 🗆 Yes 2📈 No Maryland Somerset Crisfield 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a 5030 Blue Heron Lane 21817 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. by 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Completed 3 XWidowed 4 ☐ Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Secretary Wool Brokers Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Herbert Olaf Olsson Elizabeth Marion (UNKNOWN) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald Reed (Son) <u> 5030 Blue Heron Lane - Crisfield, MD 21817</u> Baltimore, 5 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory of Delmarva: 01/04/2012 Delmar, DE 21. Signature F neral Service Lice 22. Name and Address of Facility Bradshaw & Sons Funeral Home 306 W. Main St. - Crisfield. Robert H. Bradshaw, Jr. 306 W. Main St. - Crisfield

Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ NEOPLASM UNKNOWN MAGGNANT disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) attending physician and I for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy signed by the atter in the past 12 months? Day Pregnant at time of death 5 Other (specify) Yes g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 2 No 1 Yes within 24 hours after death.

To the Funeral Director; After this certifics completely filled in by the funeral director, I Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 \(\sum \) Yes 28d. Describe how injury occurred Natural 5 Pending injury 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signatur 29d. Date signed (Month, Day, Year) 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2/80 State JAN 06 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 01/09/2012 Physician/ 10:00 A M MARIA TERESA RIVAS Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Casey House Rockville If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours **Director** 085-72-0299 1 □ M 2 🗓 F 60 05/01/1951 El Salvador Usual Residence of Deceden permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Experiment. 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 XYes 2 No MD Rockville Montgomery 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 509 Castleford Street 20851 TISA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【XNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married If Yes, Give Year or Dates 1 XYes 2 □ No Specify: El Salvador Specify: Hispanic 3 Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working 12th [Jementary/Secondary (0-12) life. DO NOT use retired) College (1-4 or 5+) Housekeeper Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Santago Rivas Rosavra Miranda 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 509 Castleford Street, Rockville, MD 20851 Marvin Lozano/son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place, 01/17/2012 | Germantown, MD All Souls Cemetery 4 Donation 5 Other (Specify, 22. Name and Address of Facility Snowden Funeral Home Funeral Servic 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Stomach cancer disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) burialphysician Physician/Medical Records, P.O. Box 68760 the use as IF FEMALE: attending 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2X No jo Month Day Year been signed by the a should be detached t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an autopsy performed page 2 certificate 2 X No Division of Vital 25. Was case referred to medical funeral director. 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\bar{X} \) Other (Specify) Hospital 2 1 Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending work?
1 Yes 2 No 24 hours after death. Funeral Director: A Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 Homicide determined filled in

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Geoffrey Coleman State

Registrar

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within 2.

Medical

29a. Certifier

only one) 29b. Signature and title of certifie

31. Date filed (Month, Day, Year, JAN 1 0 2012 1355 Piccard Drive, #100, Rockville, MD 20850

🙇 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) 01/09/2012

29c. License number

D37142

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death JAN. Physician/ DOROTHY ROSE 3,2012 1425 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner SHADY GROVE ADVENTIST HOSP. ROCKVILLE MONTGOMERY cial Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min DEC. 31, 1926 NEBRASKA 507-28-6011 85 Yrs. 1 □ M 2 🟋 F **Director** Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director r 28a-f sl notified MONTGOMERY ROCKVILLE MD. ¹X☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a o must be Funeral 9701 VEIRS DRIVE 20850 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11 Marital Status "natural", or ite dical Examiner Armed Force Black, White, etc 1 Never Married 2 Married þ 5-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Specify: WHITE 3 X Widowed 4 □ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) ADMINISTRATIVE SECRETARY COMUNICATIONS 12 other Be Maryland 17. Father's Name (First, Middle, Last) th and Mental H 18. Mother's Name (First, Middle, Maiden Surname) 2 LOTTIE HEXOM BERWIN ROGERS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 9701 VEIRS DRIVE, ROCKVILLE, MD. 20850 FRANK McGOVERN- EXECUTOR 27 Department of Health Important: If item 27 any injury or other tronce. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Removal from State SWEET MEMORY GARD, 1/30/2012THONOTOSASSA, FLA. 4 Donation 5 Other (Specify) 22. Name and Address of Facility 2222-WISCONSIN AVE., NW 21. Signature of Funeral Service HYSONG CO. $\mathcal{M}^{\text{-}}$ WASHINGTON, DC 20007 23a. Part 1. Enter the disease, or co shock, or heart failure. List only Approximate Interval Between Onset and Death at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events Advan pue the burial-trait Due to (or as a consequence of) resulting in death) Last physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Q 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an page 2 performed? Yes 2 No or Attending Physician: 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? ရို 2**X** No Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: Natural Accident 5 Pending 1 Yes 2 No Investigation within 24 hours after deat To the Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) DD066656 Januar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 medical Chr br Rockville, MD 20850 Faken Oluwapelumi 32. Regis State Registrar

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feredith Shaffer	State of Maryland / Department of Health and Mental Hygic 1- For State Registrar Certificate of Death	ene Reg. No. 2012 0178								
Physician/ Medical Examine	N. N	Oate of Death Month Day Year anuary 6, 2012 3. Time of Death 1601 hrs								
3	4a. Facility Name (if not institution, give street and number) Suburban Hospital 4b. City, Town, or Location of Death Bethesda	4c. County of Death Montgomery								
Funeral Director	Months Dave House Min	Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) DC								
and show any nce.	Usual Residence of Decedent 10a. State	10d. Inside City Limits 1 🏲 Yes 2 No								
auth with the Maryland items 23a or 28a-f sho ust he notified at once ineral Director	10e. Street and Number 4510 Edgefield Road 10f. Zip Code 20895	10g. Citizen of What Country? United States								
P F T	3 Widowed 4 Divorced in res, give rear	white, etc. Specify: White								
5-0036 led within 72 hours a dygiene. other than "natura the Medical Exami	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Office Manager	Retail								
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the Medica fo Be Comple	John P. Shaffer Margaret Walleigh									
MD 21 d 2 should th and Me n 27 is ma tumatic ev	John P. Shaffer / Father 11508 Kimbark Ct. North	Potomac, MD 20878								
≥ × ≥ = 3	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, crematory or other place) National Crematory 02/04/	2012 Falls Church, VA								
Baltimo permit. Page Department of Important: injury or oth	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Josep William A. Service Licensee 5130 Wisconsin Ave.	NW Washington, DC 20016								
Physician Medical Examiner	23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respective. List only one cause on each line. Immediate Cause (Final disease a. Fentanyl Intoxication	piratory arrest, shock, or heart Approximate Interval Between Onset and Death								
	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.									
ted Insit Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):									
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OX 6876 sath certificate attending phy or use as the	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify)	23d. Date of delivery Month Day Year								
P.O. Bares that the de signed by the be detached for by Phy		23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 VUnknown								
Division of Vital Records, P.O. talor Attending Physician: The law requires that the safter death. al Director: After this certificate has been signed by ted in by the funeral director, page 2 should be deate bartification: To Be Completed by F	Focal myocardial fibrosis; Focal chronic Hepatitis E	24a. Was an autopsy findings available prior to completion of cause of death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No								
tal Rectina: The certificate ector, page	25. Was case referred to medical 25. Place of Death (Check only of	one)								
on of Vit nding Physic th. r: After this e funeral dire Ion: To I	1 Ves 2 No lineatient 2 EN/Outpatient 3 DOA Nursing Ho	ome 5 Residence 6 Other. Describe how injury occurred known								
Division o To the Hospital or Attending within 24 hours after death. To the Funeral Director: After Completely filled in by the funeral Medical Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Found: Residence Ke	Location (Street and Number or Rural Route Number, City or Town, State) 4510 Edgefield Rd.								
To the Hosp within 24 hos Completely fi	129a Centiler	to the cause(s) and manner as stated.								
Parit Mac	29b. Signature and title of certifier O.C.M.E.	29d. Date signed (Month, Day, Year) January 7, 2012								
	30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	3								
State Registra										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month Allen Ulysses Smith 2012 10:10 A January Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Prince George's Clinton Southern Maryland Hospital If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Days 578-66-5473 Director 1XXM 2 F 61 Wash.,D.C. 02/11/1950 Usual Residence of Deced show 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f District Heights 1 X Yes 2 ☐ No Md. P.G. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 must be Funeral 23a with U.S.A. 20747 3510 S. Forest Edge Road death 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ral", or iten Examiner Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black Specify: "natural", 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done life. DO NOT use retired) (Specify only highest grade completed) during most of working Dept. of Transportation Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) U.S. Government Mailroom Supervisor vears Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental I ပ Lorraine Hobson Brown Allen Smith and l 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1109 Farmingdale Ave., Capitol Heights, Md. 20743 f Health Catherine L. Williams/Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Page 1 Burial 2 Cremation 3 Removal from State
Donation 5 Other (Specify) Maryland Nat'l. Mem Park 01/13/12 Laurel, Maryland Name and Address of Facility
Henry S. Washington & Sons Co., Inc.
1925 Burroughs Ave., N.E., Washington, D.C. 21. Signature of Funeral Service Licensee Jane 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ardian Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death the detached P.O. ģ Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has performed? 2 🗌 No 1 Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 X No မ 1 ☐ Inpatient 2 KER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Director: After 1 Natural 5 Pending М 1 Tes 2 No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital o within 24 hours af To the Funeral Di completely filled in Medical 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 06-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year

JANUALY - 05 - 2012 CECELIA 11.274 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death HALFORD HARRORA MSMORIAC HUSDITAL HAURE RACC Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** JULY 29 Hours Min. 1 M 2 X F 218-22-0931 85 Director VIRGINIA Usual Residence of Decedent 28a-f shov 10b. County 10a, State ms 23a or 28a-f sho must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MARYLAND 1 X Yes 2 No HARFORD HAVRE DE GRACE 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral 2219 WILLIAMS DRIVE 21078 UNITED STATES item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc Š 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Completed 3 X Widowed 4 ☐ Divorced Specify: BLACK Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) PAYROLL CLERK RETAIL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked or ပ WILLIAM A. GORDON ROSETTA LOCKETT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau GREGORY L. STEWART SR (SON) 201 NORTHWAY, HAVRE DE GRACE, MARYLAND 21078 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State HARFORD MEMORIAL GRD 1/12/12 4 ☐ Donation 5 ☐ Other (Specify) ABERDEEN, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
LISA SCOTT FUNERAL HOME, P.A.
552 LEWIS STREET, HAVRE DE GRACE, Scott MD 21078 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final INFARCE CEREBRAL Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☑ No Month Dav Year 1 Yes 2 9 Unknown been signed by the should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ HYPELTENSION ATHEROSCIENOSIS 1 Yes 2 No 3 Probably 4 Unknown Completed INFECTION 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 sl autopsy performed' death? within 24 hours after death.

To the Funeral Director. After this certificate is committeed filled in by the funeral director, pag 2 🗆 No Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) examiner? 2 🔀 No Other: 1 🗌 Yes ၉ 4 Nursing Home 5 Residence 6 Other (Specify) 1 DOA Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how Injury occurred 1 X Natural 5 Pending work Division 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 🛄 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title TANUALY. 05.2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSAITAL HAUNE GO GRACE MA HARROLD ME MORIAL ALANJUGATICA

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 January Arthur F. Sorrell, Jr. 1230 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chesapeake Shores Nursing Home Lexington Park Marvis 7. Age (In yrs. last birthday) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Birthplace Country) MD Funeral (Month, Day, Hours **Director** 220-40-4084 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 28a-f 1 ☐ Yes 2 🕅 No Lusby MD Calvert 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 615 Sollers Wharf Road 20657 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 0 ò Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No Specify "natural", Completed 3 Divorced Year or Dates. permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) 10 Landscaper Landscaping Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur F. Sorrell, Sr. Hannah S. Dawkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lillian Dawkins /sister 7921 Gilbert Street, Philadelphia, PA 19150 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 A Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/14/2012 John UMC Cem. Lusby, MD 21. Signature of Funeral Septice Divenses 22. Name and Address of Facility Sewell Funeral Home Dares Beach Rd., Prince Fred., MD20678 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events and resulting in death) Last burial attending physician for use as the buria Physician/Medical that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month 4 Pregnant at time of death 9 Unknown Yes 2 No the 9 Unknown P.O. ģ Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law Jas autopsy page death? certificate 1 ☐ Yes 2 M No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending death. Accident
Suicide Investigation within 24 hours after death

To the Funeral Director,

completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Narse Prestioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signatur of death (Item 23a) (Type, Print) 18M Misso Physician 74051 31. Date filed (Month, Day,

State Registrar 32. Registra s Signature

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		for State Registrar					ertifica					Reg. N	0.0	112	0.1	788
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Examin	ier	Holy Cro			noerj				Sprin			4c. County of Death Montgomery				
Funeral		5. Social Security No		6. Sex	7. Age (In yrs.	last birthda		ler 1 Year	If Under 2		8. Date of Bi	irth			place (State o	or Foreign
Director		181-34-37 Usual Residence of		1 □ M 2 🔀 F	8:	5 Yrs		Julyo	110010		06/25				igland	
and show	ē	10a. State	10b. County			10c. City, Town or Location								10d. Inside City Limit		
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f Heal item item		Ray G. S 20a. Method of Disp	osition		20b.	Place of Dis	sposition (Na	ame of			kway #3 ^{Date}				own, State	21/0
Page nent o ant: If Iry or		1 🗌 Burial 2 l 4 🔲 Donation	Cremation 5 Other (S	3 ☐ Removal from Specify)			rematory or r Cre			1/04	4/2012	Fre	deri	ck.	MD	
permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. The stronghorth if them 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fur	neral Service L	icensee	1 2 2						auffer					١.
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hysician/ Medical			r Vailure. List o Final	complications that only one cause on each on		irati		,		ardiac d	or respiratory a	irrest,		4	Approximation Interval Bet Onset and	tween
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To the hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affer death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medica	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	ponths?	1 🔲 Live	tcome of pregn Birth 2 Fet gnant at time of nown	al death	3		БУ			:		d. Date of delivery Month Day Year		Year
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sician: The law require certificate has been si irector, page 2 should I	Completed										24a. Was		24b. V	Nere auto	psy findings	available
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nding ath. r: After re fune	icate	1 🔼 Natural 2 🗌 Accident	5 Pendin	(Mon	th, Day, Year)	injur		work			280. Describe	now inju	iry occurre	50		
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to the hospital or Autending Prysician: The la within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	(Check 2		Physician: To the base examiner: On the base Nurse Practitioner	sis of examinatio	on and/or inv	estigation, in	n my opinic	on, death occ	curred at	the time, date	and plac	e, and due	to the ca	use(s) and ma	anner state
Nith To 1		29b. Signature and t	title of certifier	str'			- 1	oc. License		G		29d. Da	ate signed	(Month,	Day, Year)	
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)									2012					
9				who completed caus 500 Forest		, , , , ,		r Cn-	ine '	MD o	0010					
Stat		 Date filed (Month) 	n, Day, Year)	32.	egistrar's Signa	ature	La W	Jope	TIIR 1	ענויו ב	.0710				-	
Registra	ar	la.	JAN 0 5	2012	recen	p. 7	A CARRO									

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day B Joan Elizabeth Shaffer 5:00 Medical January 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Salisbury Wicomico 908 Rosalie Way Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Min 166-16-0738 **Director** 1 🗆 M 2 🗶 F 91 01/14/1920 England 28a-f show with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director Maryland 1 X Yes 2 No Wicomico Salisbury ms 23a or must be r 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 908 Rosalie Way 21804 USA items be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. ö þ 1 Yes 2 No If Yes, Give Year or Dates. 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify. 'natural" Completed 3 Widowed 4 Divorced Specify. White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Government Secretary event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F မ Cyril Sadler Elsie Lee traumatic Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health au Important: If item 27 is any injury or other traconce. Lila Meckley/daughter 30381 Mallard Dr., Delmar, MD 21875 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State 1/11/2012 4 ☐ Donation 5 ☐ Other (Specify) Edgewood Memorial Park Glen Mills, PA Signature of Funeral Service Licensee Name and Address of Facility Holloway Funeral Home Professional Association Snow Hill Rd. Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) as a consequence of Examiner andi Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury that initiated events Exami burial-transit Due to (or as a consequence of) resulting in death) Last physician Physician/Medical that the death certificate be P.O. Box 68760 the as attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Yes 2 No been signed by the a should be detached t 9 I Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has page 2 autopsy death? certificate 1 Yes 2 No Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 🗌 Yes 2 -10 9 1 Inpatient 2 ER/Outpatient 3 DOA Director; After this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No Natural 5 Pending hours after death. filled in by the Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a

To the Funeral E

completely filled Medical crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier Day, Year)

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DHMH 17 Rev 06-2011

Registrar

31. Date filed (Mo

em 23a) (Type, Print

egistrar's Signatur

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ddress of person who completed cause of death

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
Amend 25 per med cert G924 2/1/12 dk
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 20 17 Louella Sterling 4:00 A anuarv Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 5107 Alfred Drive Waldorf Charles 8. Date of Birth (Month, Day, Year) April 15, Age (In yrs. last birthday) 1 Year Days If Under 24 Hrs. Hours Min. 9. Birthplace (State or Foreign **Funeral** 1939West Virginia 1 □ M 2 🗶 F Months 72 Director 236-56-8638 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director 1XX Yes 2 No Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5107 Alfred Drive 20601 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates White Completed 3 Widowed 4 Divorced Specify 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Salesperson Montgomery Wards Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ည Norman Thomas Rose Mary Mildred Hoover 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Sterling/ Husband 5107 Alfred Drive, Waldorf, Maryland 20601 permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other 3 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1🎾 Burial 2 🗌 Cremation 3 🔲 Removal from State 4 Donation 5 Other (Specify) Jan 6, 2012 |Charleston, W.V Hills Mem. Park_ 22. Name and Address of Facility Huntt Funeral Home Signature of Funeral Service Licensee 3035 Old Washington Rd. Waldorf, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence Examiner Sequentially list conditions, Physician/Medical Examiner Due to or as a consequence of if any leading to immedicause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-trar Due to (or as a consequence of): Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Dav 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 3 Probably 4 Unknown 1 Yes 24a. Was an 24b. Were autopsy findings available within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performed? Yes 2 M No prior to completion of cause of death? 2 🗌 No 1 🔲 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Nesidence 6 Other (Specify, ည 1 Tes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work? 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 29c, License number 29d. Date signed (Month, Day, Year) D2103 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 249- Waldorf, MD. 21100L Michael 31. Date filed (Month, Day, Year) 82. Registrar's Signature State JAN 0 5 201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Arthony John Slechta 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Wicomic *alisbun* Peninsula Regional Medical Center If Under 1 Year If Under 24 Hrs. Date of Birth Birthplace (State or Foreign Country) **Funeral Director** 1 XM 2 F 59 2/1/1952 MD ms 23a or 28a-f show must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Yes 2 No MD Worcester Snow Hill 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 21863 USA 310 Purnell St. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Examiner Black, White, etc. ō þ 1 Never Married 2 X Married 1 Yes 2 XNo Baltimore, Maryland 21215-0036 Hygiene. other than "natural", 1 Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) other traumatic event, the Disabled other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Joseph Vincent Slechta Dorothy Lillian Kremer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Therese Tyndall (sister) Birch Place Berlin, MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) First State Crematory 1/9/2012 Millsboro, DE 22. Name and Address of Facility The Burbage Funeral Home 108 William St. Berlin. MD 21811 23a. Part 1. Enter the shease, complications that colled the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause only a hiline. Approximate Interval Between Immediate Cause (Final Cabulletian Asytale Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner My Listrason Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events 4 care Jucy Coronar Due to (or as a consequence of): resulting in death) Last Physician/Medical 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant Box (3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery in the past 12 months? Day Pregnant at time of death 2 No 1 | Yes 2 L Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Lymphana Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📈 Unknown DINATO Schran affition, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 25ch emi Carro my 1 Yes 2 No Yes 2 No Hospital or Attending Physician; Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 Z No Other: 은 1 Inpatient 2 ER/Outpatient 3 A DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury after death. 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical Lecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the I within 2 only one 29b. Signature and title of certifier DYYUGG 2017 30. Name and addit of person who completed cause of death (Item 23a) (Type, Print)

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death Month Physician/ Smith Wilma Mae JAKUARY 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Washington Hagerstown Meritus Medical Center Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthdav) 8 Date of Birth **Funeral** (Month, Day, Year) Director 213-24-9538 83 1 □ M 2 🗓 F 1928 Mar 30, Maryland 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 X Yes 2 □ No Maryland Washington Boonsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 302 North Main Street 21713 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕅 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or ite Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 ☐ Divorced Completed White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Owner/Operator Restaurant event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Bonita Colbert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sh tment of Health a tant: If item 27 is Cynthia J. Kauffman/daughter 416 North Main Street Boonsboro, Maryland 21713 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other placel 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 01-11-2012 Boonsboro, Maryland Boonsboro Cemetery 21. Signature of Funeral Service (Incen-22. Name and Address of Facility Bast-Stauffer Funeral Home, PA 7606 Old National Pike Boonsboro, MD 21713 23a. Part 1/Enter the disease, or complications shock, or heart failure. List only one cause that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Cerebrovascular accident disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Athroschisis years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events mellitus Teens-Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ signed by the atter in the past 12 months? Pregnant at time of death 2 1 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an this certificate has performed 2 No 1 Yes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Hospital: Other: 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 24 hours after death. Funeral Director: After Hospital or Attending 1 Natural (Month, Day, Year) 5 Pending Accident 1 Yes 2 No Investigation filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🔟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 244996 phans Rd Boonsbor MD 21713 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAlik MD 20311

State Registrar

DHMH 17 Rev 06-2011

Date filed (Month)

Please Type or Print in Black Indexible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** <u>7:15</u>pm [™] 2, 2012 Encarnacion Sanabria January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Shady Grove Genesis Health Care Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthdav) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🖾 F Director 322-52-4035 87 March 25. 1924 Guatemala Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified of once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Directo Maryland North Potomac Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10622 Chisholm Landing Terrace 20878 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No þ Specify: Guatemalan Specify: White 3₺ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Enriqueta Paredes Oscar Amaya 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10622 Chisholm Landing Terrace, N. Potomac, MD 20878 Anabella Garcia (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/5/2012 All Souls Cemetery Germantown, Maryland 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licen 10 East Deer Park Driv Gaithersburg, MD 20878 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiac Arrythmia Instant /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): burial-Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 🔀 No the 9 Unknown signed by the detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Parl I. 23e. Did tobacco use contribute to the cause of death? ş Parkinson's Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4x Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Diabetes Mellitus 24a. Was an autopsy page perform 1□ Yes 2 X No rector, Be 25. Was case referred to medical examiner? 26. Place of Death Check only one) Hospital: Other: 4 🗷 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) ပ 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death

To the Funeral Director:,
completely filled in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier

State Registrar

JAN 05 2012 DHMH 17 Rev 1/2001

Ravi Passi, M.D.,

31. Date filed (Month, Day, Year)

ORIGINAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D28656

15245 Shady Grove Road, #130, Rockville, Maryland 20850

29d. Date signed (Month, Day, Year) January 2, 2012

		State of Maryland / Dep		lental Hygiene							
	1	- FOF	rtificate of Death	Reg. No. 2012 01794							
Physician	_	1. Decedent's Name (First, Middle, Last)		Date of Death Month Day Year 3. Time of Death							
/Medical	1	RICHARD O. SEIDENSPINNER	4b. City, Town, or Location of Death	January 5, 2012 12:17 A M							
Examiner	-	4a. Facility Name (If not institution, give street and number) 28052 Holland Crossing Road	Marion Station	Somerset							
Funera!		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	THE CASE IN THE CASE I	8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Country) Distric							
Director	-	228-42-4649		09/30/1931 of Columbia							
at	-	10a. State 10b. County 10c. City, Town or L.	ocation	10d. Inside City Limits							
or 28a-f sł be notified	5	Maryland Somerset Mario	n Station	1 □Yes 2 XINo							
be no		10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?							
r items 23a	200	28052 Holland Crossing Road 11. Marital Status 12. Was Decedent Ever in U.S. 13.	21838 Was Decedent of Hispanic Origin? (Spiff Yes, specify Cuban, Mexican, Puerto	U.S.A. scify Yes or No- 14. Race - American Indian,							
or iter		Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 □ No 1 □ Widowed 4 □ Divorced 1 □ Yes, Give □ Inknown									
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giene.	5	Elementary/Secondary (0-12) College (1-4or 5+)	trician	DC Government							
tal Hy d othe event,		17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Maiden Surname)							
Marken narken	2	Fred Seidenspinner	Jane Os								
Ith and 27 Is n traun				al Route Number, City or Town, State, Zip Code)							
Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Europea Director		20a. Method of Disposition 20b. Place of Disposition		Fredericksburg, VA 22406 20c. Location - City or Town, State							
ment c		1 🗀 Buriai 2 💢 Cremation 3 🗀 Hemovai from State		6/2012 Delmar, DE							
nports ny inj		21. Signature of Eneral Service Licensee	2. Name and Address of Facility radshaw & Sons Fun	eral Home							
70 = e O	+	Robert H. Bradshaw, J	<u>06 W. Main St C</u>	risfield, MD 21817							
		shock, or heart failure. List only one cause on each line.		Interval Between							
nysician /Medical		disease or condition resulting in death) a. Due to (or as a consequence of):	reinome of the	mo.							
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tificate tor, pa	D	25. Was case referred to medical	26. Place of Deat	1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No n (Check only one)							
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after death. Director: After it in by the funera	Car	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury. At home, farm, s		28f. Location (Street and Number or Rural Route Number,							
al Dire	- E	4 ☐ Homicide determined building, etc. (Specify)		City or Town, State)							
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To the comp	M	29b. Signature and title of certifier + Common Com	29c. License number 0 0014314	29d. Date signed (Month, Day, Year)							
12/1		30. Name and address of person who completed cause of death (Item 23a) (Type PANPITP, KLUG, 100 E.C.	Print) 2011/2/101, Sal	lis Luy, Md. 21801							
State Registrar	-	30. Name and address of person who completed cause of death (Item 23a) (Type PANPITP, KLUG, 100 E.C. 31. Date filed (Month, Day, Year) JAN 06 2012 32. Registrar's Signature	backer	<i>f</i>							
	_										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 11, 2012^{Year} <u>Alan Jay Silver</u> January Medical 1:00 A 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Upper Marlboro 9325 Fairhaven Ave. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Days 060-34-3632 **Director** 1 🕅 M 2 🗆 F Jan. 13, 1943 New York 68 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🗓 No Upper Marlboro Maryland Prince Georges 10e. Street and Numbe ō 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a on the Medical Examiner must be Funeral U.S.A 9325 Fairhaven Ave. 20772 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Black, White, etc by 1 Never Married 2 X Married ☐ Yes 2 **XX**No Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates. 1 ☐ Yes 2XX No Specify. 3 Divorced Specify: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Sydney Silver Shirley Jacobs injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 7008 Foster St. District Heights, MD 20747 Darlene Silver (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1

Burial 2

Cremation 3

Removal from State January 12, 4 ☐ Donation 5 ☐ Other (Specify) 2012 Clinton, MD Lee Crematory 21. Sign ure of Funeral Service Licen see MO1555 Lee Funeral Home, Inc. 22. Name and Address of Facility 6633 Old Alexandria Ferry Rd. Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final Ph. sician/ av bey ovouan disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Atheros clestic arti Sequentially list conditions, in any, reading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last depender and the burial-tran Due to (or as a consequence of) physician Physician/Medical Diabetie 28 Division of Vital Records, P.O. Box 68760 use as attending IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year 4 ☐ Pregnant 9 ☐ Unknown Pregnant at time of death should be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy I Director: After this certificate 1 Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) 10 Hospita 2 No 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State within 24 hours To the Funeral Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, de ath occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of cert 29d. Date signed (Month, Day, Year) 00042040

State Registrar Me

31. Date filed (Month, Day

Elle

2

30 Name and address of person who completed cause of death (Item 23a) (Type Print)

100 Pfec Marillacvo

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amary 12, 2012

MUD-

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Miranda Leonette Stokes 9 Jan 2012 320 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Holy Cross Hospital Silver Spring Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 579-02-2037 **Director** 1 □ M 2 💢 F 35 05-05**-**1976 Wash. DC Usual Residence of Decede 28a-f shov 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location with the Maryland notified at Director MD Silver Spring Montgomery 1 Xyes 2 No 10f. Zip Code ō 10e. Street and Number 10g. Citizen of What Country? must be Funeral 23a 20903 529 Southampton Dr. #A USA items Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. Medical Examiner 1 Never Married 2 Married ŏ 2 1 ☐ Yes 2 X No If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black "natural" Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working al Hygiene. d other than " National Medical life. DO NOT use retired) Elementary/Secondary (0-12) the Association Accountant other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F မ Anthony Jackson Wanda Stokes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trains Wanda Cox/ Mother P.O. Box 186 Columbia, MD 21046 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c, Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Ft. Lincoln Cemetery | 1-17-2012 | Brentwood, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licen 22. Name and Address of Facility Ronald Taylor II FH 10583 Middleport Ln. White Plains, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ a. Sepsis

Due to (or as a consequence of): disease or condition Days Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last use as the burial-tran and Due to (or as a consequence of): nding physician Physician/Medical • Hospital or Attending Physician: The law requires that the death certificate be to thours after death.
• Funeral Director: After this certificate has been signed by the attending physicial P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death signed by the at Id be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Pneumonia, Metastatic Breast Cancer, 1 Yes 2 No 3 Probably 4 X Unknown Completed Multiorgan System Failure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? funeral director, page 2 1 ☐ Yes 2 😾 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 6 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5 Pending X Natural injury Accident Investigation completely filled in by the 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 only one 29b. Signatu and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number D0057630 01-09-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 06-2011

State

Silver Spring, MD 20910

Glen Rd.

500

Forest 32. Regist ar's Sign dure

Anuradha Arun

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

Andrea Rena Sh		1- For State	State of Maryla		artment of		and Mental	-	eg. No. 2 (012 0179			
Physicia Medical Examii	ın/	1. Decedent's Name (First, Mi	ddle Last) ReNa	Shak	7007			2. Date of Dea Month January 9	ith	3. Time of Death			
		4a. Facility Name (if not institu Bowie Health Cente	ition, give street and nu	imber)	rei i	4b. City, Town	, or Location of Dea		4c. County of	f Death			
Funeral Director		5. Social Security Number 21531 1418	6. Sex	7. Age (In yrs.	last birthday) Yrs	If Under 1 \		Irs. 8. Date of Bir	rth (MM/DD/YYYY)	9. Birthplace (State or Foreign Country)			
Maryland 28a-f show any d at once.	or	Usual Residence of Decedent 10a. State 10b. Count 10b. Count 10b. Count	·	10c. City	, Town or Locati	ion		1 0/3	77.00	10d. Inside City Limits 1 Yes 2 No			
h the Maryl 3a or 28a-i	uneral Director	10e. Street and Number	Road			10f. Zip Cod	716	1	10g. Citizen of What Count				
6, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Titem 27 is marked other than "natural", or items 23s or 28s-f short traumatic event; the Medical Examiner must be notified at once.	by Funera	11. Marital Status 1 Never Married 2 3 Widowed 4 1		2 No		es, specify Cul	Hispanic Origin? (ban, Mexican, Puer No specify:		14. Race - White, Specify:	American Indian, Black, etc.			
036 tthin 72 hours ne. r than "natur fedical Exami	Completed t	15. Decedent's Education (S) Elementary/Secondary (0-1:	pecity only highest grad			ost of working	pation (Give kind of life. DO NOT use n		0)	Cestaurant			
D 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medica	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Michele V. Proctor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Num er, City or Town, State, 2											
re, MD 2 I and 2 shou Health and IN fitem 27 is n	<u>۵</u>	Michele Proce 20a. Method of Disposition	ctor/mo		Place of Disposi	Mt OA	k ROAD	Bowle Date	MD 20	City or Town, State			
Pages Pages ment of	-	1 Burial 2 Cremati 4 Donation 5 Other 21. Signature of Funeral Service	Specify:	om State	crematory or oth		ess of Facility	23/2012	Beltsu	ille MD			
Balt Balt Depart Import injury		23a. Part I. Enter the disease,	or complications that ca	aused the death) 4	25 MA	NAMO K	or respiratory arri	LUASh lest shock or hear	t Approximate Interval			
/Medical Examiner		failure. List only one cause Immediate Cause (Final diseasor condition resulting in death)	se on each line. Seizu: se a	consequence	rder					Between Onset and Death			
	Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence of									
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- 8 GE	Medical	AMENDED 23a,27, per ME g923 1/27/12 TRT IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery											
certification	Physician/Me	3b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 ✓ U	23d. Date of d Month	Day Year									
P.O. es that the igned by the detache	2	Part II. Other significant cond	litions contributing to	death but not r	esulting in the u	nderlying caus	e given in Part I.	23e. Did to		ute to the cause of death? Probably 4 Unknown			
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Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Co	uld not be ermined (Specify)		ome, farm, stree			or Town, S	tate)	or Rural Route Number, City			
DIV To the Hospital or within 24 hours after Completely filled in	edica	(Check only one) 2 Medical Ex	Physician: To the best aminer:On the basis o and manner st	f examination a									
	Σ	29b. Signature and title of certif	fier				nse number C.M.E.		29d. Date signed January 10,	(Month, Day, Year) 2012			
9		30. Name and address of person Ana Rubio MD. As	on who completed causessistant Medical E		,	more Stree	t, Baltimore, M	ID 21223	• • • • • • • • • • • • • • • • • • • •				
Sta Registr	te ar	31, Date filed (Month, Day Year) 32. Registrar's Signature											

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Brandon Kurtis Shoemaker 1- For State

		Registrar			Ce	ertificate	of Do	eath					0		<u> </u>	
Physi		1. Decedent's Nar	ne (First, Midd	dle,Last)							2. Date of D	Reg. N eath	0.		3. Time of Death	
Medical Exa	min			is SHOEMA						1	Month	nuary 17, 2012 Year 1200 hrs				
		4a. Facility Name	(if not institution	on, give street and n	umber)		4b. C	ity, Town, o	r Location	of Death	January		4c. County of	Dooth		
		17704 Leo	nard Ave					agerstow					Washingt			
Funera		5. Social Security	Number	6. Sex	7. Age (In yrs.	last birthda	Under 1 Yea	er 24Hrs.								
Directo	or	215-27-4	400	1XM 2 F	27		М	onths Day			Foreign (State of					
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E	ا اب	Maryland	Wa	shington	1.00. 0.0	, TOWN OF E								- 1	10d. Inside City Limits	
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th wi	Funeral	11. Marital Status		12. Was Dec	edent Ever in U	.S. 13.	Was Dec	edent of His	spanic Orig	gin? (Spe	cify Yes or I	No-	14. Race -	Americ	an Indian, Black,	
dear dear		1 X Never Marri	ed 2 M	arried Armed F	2 X No		If Yes, sp	ecify Cuban	i, Me xican	, Puerto R	ican, etc.)		White,	etc.	ar maidi, Didok,	
after	<u> </u>	3 Widowed		orced If Yes, Give Yes	ər	1	Yes	2 X No	specify:			Specify:	whi	te		
nours			ducation (Spec	cify only highest grad	de completed)	16a. Dece	dent's Us	ual Occupat	ion (Give I	kind of wo	rk done	116b	Kind of Busir	ness/In	duetry	
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5-06 led wit Hygien other	၂ ပ					<u> </u>			18.Mother	s Name /F	irst, Middle					
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D 21215-(should be filed v and Mental Hygi 7 is marked oth	2	19a. Informant's Na				19b. Ma	iling Addre	ess (Street					ity or Town,			
e, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. The and Panarked other than "natural", or items 23a or 28a-fahe transmise event, the Medical Examiner must he notified a contract of the cont		Katrina	Shoemak	ker - moth	ner	17	704	Leonar	d Av	e. I	lagers	amber, c stown	n, Md.	State, 2	Zip Code) 740	
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nt of other other		1 🔀 Burial 2	Cremation	3 Removal fro	om State	rematory or	other pla	ce)	- 1			1	Location - Cit	-		
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Baltimory permit. Pages 1 Department of I Important: If injury or other		21. Signature of Fur	Service I	Photos of the second		' I		nd Address		TITITI	NICH E	UNE	RAL HO	ME		
Physician		23a Part I Enter the	disease or	" Jun	mil		15 E	. Wil:	son E	11	77		. 34	d.	21740	
/Medical		23a. Part I. Enter the failure. List only	one cause of	omplications that ca on each line.	used the death.	Do not ente	r the mod	e of dying, s	such as ca	rdiac or re	spiratory ar	rest, sho	ck, or heart	- 1	Approximate Interval	
,≅xaminer		Immediate Cause (F	inal disease	a. Narcoti	c Intox	icati	on							- 1	Between Onset and Death	
		or condition resulting	g in death)	Due to (or as a	consequence of):								\rightarrow		
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ath ce	iğ.			4 Pregna	nt at time of dea	th -	Other (Sp		_cotopic p	regriancy			Month	Day	Year	
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Division of Vital and Attending Physician. rs after death. al Director: After this certi led in by the funeral director	Be	25. Was case referred examiner?	to medical	Hospital: 1				26.Place of	Death (CI	neck only	one)					
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ior /	ğ۱	3 Suicide 6	Could n	ot be 28e. Place of	of Injury - At hom	e, farm, stre	et, factory	, office build	ding, etc.	28f.	Location (S	treet and	Number or	Rural F	Route_Number, City	
Division of Vita Hospital or Attending Physicis 24 hours after death. Fuocral Director: After this ce tely filled in by the funeral direct		4 Homicide	determin	ned (Specify)	Fou	nd:Re	side	ice		1	or Town, St gerst	ate) /	// 11/4 1.4	20na	ard Ave.	
Division To the Hospital or Attent within 24 hours after death To the Fuocral Directors	ल्	29a. Certifier 1 Ce	rtifying Phys	iclan: To the best o	f my knowledge,	death occu	rred at the	time date :	and place	and due t	a Alba a sauce	(-)				
To the Ho within 24 I To the Fu	l eg	one) 2 V Me	dical Examin	ner:On the basis of e	examination and	or investiga	tion, in m	y opinion, de	eath occur	red at the	time, date a	nd place	manner as sta	ated. the car	use(s)	
6747	ž į	9b. Signature and title	of certifier	Sing manner state	5u.			c. License nu								
		() (a	Kinh	1111)				O.C.M.E			- 1		ite signed (M		∠ay, rear)	
	3	0. Name and address	of person who	o completed source	of doors (u - · · · ·							Janua	ary 18, 20	12	j	
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Sta	ite 3	Date filed (Month, L	Day Yearl		trar's Signature	JU VV. D	ammore	Street, E	aitimor	e, MD 2	1223					
Registr	ar	1 8 8	0 9 2N	19 Aregis	uar s signature	bar	1.1									
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mary Alice Shamburg 12859P dhuard Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Prince George's Examiner 4b. City, Town, or Location of Death Doctors Community Hospital Lanham Social Security Number 8. Date of Birth 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Hours Days May 15, 1935 169-28-5730 Director 1 🗆 M 2 🔀 F 76 Pennsylvania 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Director any injury or other traumatic event, the Medical Examiner must be notified Maryland Prince George's Adelphi 1 🗆 Yes 2 🖁 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 20783 2501 Pawnee Street United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, 1 Never Married 2 X Married Completed by 1 Yes If Yes, Give Shamburg, Ma. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. White Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Customer Service University of Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Theodore Cabo Wava Gill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynn Hutchison -daughter 1407 Pennington Court Edgewater, Maryland 21037 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Crematory 20c. Location - City or Town, State Date 1

Burial 2

Cremation 3

Removal from State 1/16/2012 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Bonaria V: Bofgwardt Funeral Home, PA 4400 Powder MIll Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Hepatic Encephalopathy disease or condition Medical Due to (or as a consequence of) Examiner Respiratory Insufficiency Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of Examir that initiated events resulting in death) Last Due to (or as a consequence of) use as the burialattending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No ρ Month Day Year Pregnant at time of death ed by the a Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an cate has page 2 autopsy performed? Yes 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death Certificate: 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 5 Pending work?
1 Yes 2 No s after death.

I Director: A

ed in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after

To the Funeral Direct

completely filled in b Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
☐ Certifying Nurse practitioner: To the best of my homology, death occurred at the time, date and place, and due to the cause(s) and manner stated
☐ Certifying Nurse practitioner: To the best of my homology, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 1/14/12 MIDD 60925 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Elizabeth Fasika, MD 8118 Good Lucked, Lankam, MD 0 20706 32. Registrary Signa Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. and #5 PER FH G927 5/11/2012 JH. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SHERALD 13,2012 Year Physician/ GOLIBART MADELETNE JANUARY 9:23A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK MEMORIAL HOSPÍTAL FREDERICK FREDERICK If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Date of Birth 5. Social Securit 8 444 per 6. Sex **Funeral** (Month, Day, Year) Days Hours 219-14-8514 **Director** 1 🗆 M 2 😿 F 88 Yrs February 5, 1923 Pennsylvania Usual Residence of Decedent artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director Frederick 1 X Yes 2 No Frederick Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States of America Page 1 and 2 should be filed within 72 hours after death with 21701 17 East Second Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 2 X No 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 Divorced White Year or Dates. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Banking Administrative Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Margart Rohrback ည Mark Julian Golibart 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 11919 Green Valley Road, Union Bridge, Maryland 21791 Geneva Delphey / Friend 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or oth January 14, 1 Burial 2 X Cremation 3 Removal from State Smithsburg, Maryland Smithsburg Crematory 4 Donation 5 Other (Specify) 2012 21. Signature of Functal Salvice 22. Name and Address of Facility Keeney & Basford P.A. Funeral Home M01433 106 East Church Street, Frederick, Maryland 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ C 90 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examiner If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy ate has been signed by the atter page 2 should be detached for i in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown vaplace ment U4) 4 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed 1 Yes 2 No Yes 2 No 24 hours after death.
Funeral Director: After this certifica etely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 27. Manner of Death Certificate: 28d. Describe how injury occurred Natural Accider injury 5 Pending 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated completely (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0968 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) erick MI 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Same11a Turner Armstrong 2012° 12:38 P.M January Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Montgomery Suburban Hospital Bethesda Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1913 1 M 2 X F Months Days Hours Min. 579-05-5983 98 **Director** South Carolina August Usual Residence of Decedent show 10b. County with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director notified 28a-f District of Columbia Washington 1 X Yes 2 No 10e. Street and Number 10f. Zip Code ŏ 10g. Citizen of What Country? must be 23a Funeral 20002 United States 1230 Oates Street, N. E. items death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status Was Decedent Ever in U.S. 14 Bace - American Indian Examiner Armed Forces?
1 ☐ Yes 2 🗶 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ō Completed by 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give Specify: **Black** "natural" 3 X Widowed 4 Divorced Year or Dates ed other than "nature event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. U.S.Dept. of Treasury **Clerk** 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked 2 Be11 Strothers Health and Ment tem 27 is marke other traumatic Fred Armstrong 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **Georgia** Debra Rene Roache (Grand daughter) 934 Garden Walk Blvd.; Apt. 814; College Park, 30349 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State tment of I rtant: If its ijury or of X Burial 2 ☐ Cremation 3 ☐ Removal from State Important: It any injury or 4 Donation 5 Other (Specify) Lincoln Cemetery Brentwood, Maryland gnatur Funeral Serv 22. Horton Company Morticians, Inc.;600 Kennedy Street, N.W.; Washington, D.C.20011 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Sudden Cardiac Death disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Possible Cardiac Arrhythmia Sequentially list conditions, Examine Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or iinjury The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown P.O. I signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, Advanced Alzheimer's Disease 1 Yes 2 No 3 Probably 4 Number page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? Hypertension 24a. Was an has autopsy performed? 1 Yes 2 No 1 Yes 2 No or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital ဂ္ To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this of completed filled in by the funeral directors. 1 Inpatient 2 X ER/Outpatient 3 I DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🛚 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) les 6,2012 D0054566 January 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sunitha Bhogavilli, M.D.;9801 Georgia Avenue; Suite 117; Silver Spring, Maryland 20902 31. Date filed (Month, Day, Year State JAN 1 0 2012 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death L. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 4250 AM JANUARY Martha Beverly Thomas Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ADNE ARUNDEL MEDICAL GLEN. BURNIE WASHINGTON 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, July 22, Social Security Number **Funeral** 1 □ M 2 🖵 F **Director** 218 54 9426 61 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland **Funeral Director** notified MD Anne Arundel 1 Yes XX No Glen Burnie ō 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? must be 7900 Benesch Circle Apt 838 21060 United States "natural", or item edical Examiner n 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ☐ Yes 2X No If Yes, Give Year or Dates 1 Yes 2 No Specify Specify: White Completed 3 Widowed 4 Divorced the Medical Decedent's Education 18a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ntal Hygiene. ed other thar event, the N Elementary/Seconday (0-12) College (1-4 or 5+) Florist Safeway Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) မှ item 27 is marked other traumatic ev John Emory Tippett Martha Thelma Beall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Windy Wallin (Daughter) 826 Elmhurst Road, Severn, MD 21144 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 1/10/2012 Resurrection Cemetery Clinton, MD Sign ture of Funeral Service Licenses 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. nterval Between Immediate Cause (Final Onset and Death 10mo anuno Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 19 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) ပ္ 1 🗌 Yes 2 HNO 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 5 Pending 1 Natural Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certification 29c. License number 29d. Date signed (Month, Day, Year) gnuan

DHMH 17 Rev 7/2009

State

Registrar

Registrar's Signature

Connu.

Mosi an

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BALIMONE

JAN05

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 1:54 A M January Francis Anthony Tortoro, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Frederick Walkersville Glade Valley Center Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Days Hours Min **Director** 220-22-8523 ĩ 924 87 Jan. Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No Maryland | Frederick Walkersville 9 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? pe I ral", or items 23a Examiner must be by Funeral 56 West Frederick Street 21793 U.S.A. Page 1 and 2 should be filed within 72 hours after death vent of Heath and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items ury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian rmed Forces?

Yes 2 \(\subseteq \) No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. WW II 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ygiene. ked other than "n revent, the College (1-4 or 5+) Elementary/Seconday (0-12) Barber Barber Shop Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) မ Frank Joseph Tortoro Anna Marie Leva 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Francis A. Tortoro, Jr. Son 102 East Street, Thurmont, Maryland 21788 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Blue Ridge Cemetery 20c. Location - City or Town, State ■ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or 1-5-2012 Thurmont, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Strvice Licerse 22. Name and Address of FacilityRobert E. Dailey & Son F.H., P.A. Klaste 615 East Main Street, Thurmont, Maryland 21788 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. Maria disease or condition Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, Examine If any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events and burial-tran Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery Live Birth 2 Li retail 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month ed by the a g Unknown g Unknown P.O. I signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy Dementia perform certificate 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 🔊 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 2 × No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA nours after death.

neral Director: After this affiled in by the funeral di this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hound To the Funer completed file 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗷 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

29b. Signature and title of certifier

State Registrar

Transe CRUP 6695 31. Date filed (Month, Day, Year) Registrar's Signature JAN 0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stoneridge Court Frederick, Web 21702

ROSUGU3

29d. Date signed (Month, Day, Year)

1-1-2012

the

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State of Mary		artment of H tificate of D			211	12 01804							
			Registrar 1. Decedent's Name (First, Middle, Last)	Cer	- Lincate of D	eau i	2. Date of Dea	th	3. Time of Death							
	Physicia Medic		Thomas Herson Townsend	3			Januar Januar	y 6, 201								
· 1	Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or			f Death								
	Funeral		5926 Tappan Lane 5. Social Security Number 6. Sex 7. Age (fr.	yrs. last birthday)	Salisbu If Under 1 Year	If Under 24 Hrs.	8. Date of Birtl	1	omico 9. Birthplace (State or Foreign							
E	Director		220-01-8282 1 🗷 M 2 🗆 F 8	2 Yrs.	Months Days	Hours Min.	(Month, Day 09/29/1	Day, Year) Country)								
Ţ	show	١٥	Usual Residence of Decedent 10a. State 10b. County 10	c. City, Town or Lo	cation		03/23/1	223	10d. Inside City Limits							
A park	28a-f	Director	Maryland Wicomico	Salisbur	Y				1 🗆 Yes 2 🔀 No							
th th	23a or	ralD	10e. Street and Number 5926 Tappan Lane		10f. Zip Code 21801			10g. Citizen of Wh USA	nat Country?							
400	tems ?	Funeral	11. Marital Status 12. Was Decedent Ever		Vas Decedent of His			14. Race	ce - American Indian,							
36	allel or i xamin	δ	1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced Armed Forces? 1 👿 Yes 2 ☐ No If Yes, Give Year or Pates Armed Forces?		Yes, specify Cubar		ricari, etc.)	Black, Specify:	White, etc. White							
21215-0036	natura lical E	Completed	15. Decedent's Education	Corp 16a. Deced	lent's Usual Occupa	ition		16b. Kind of Bus								
121	than "	omo	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	life. Do	kind of work done do D NOT use retired)		ng	Gas								
d 2	Hygie other ent, th	Be	17. Father's Name (First, Middle, Last)	Regio	onal mana	18. Mother's Name	e (First, Middle,									
ylan	Mental arked atic ev	12	James Henry Townsend			Hannah	Adams									
Maryland	permit, rage 1 and 2 aloud be threw which 2 hours are beautiving the wayyand Department of Health and Mental Hygiene. I be provided at the 23a or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)													
Baltimore,	t of He liftem or othe		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State	20b. Place of Dispo cemetery, cren	sition (Name of natory or other place	9)	Date		City or Town, State							
Itim	artmen ortant: injury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signatu/e of Funeral Service Licensee	Parsons C	-	1/9/		Salisbu								
Ba	Impor Impor any in		De A . Comment		501 Snow	Hill Rd.	ome Pro , Salis	sbury, MI	al Association 21804							
∴PI	wsicine/		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Approximate Interval Between Onset and Death 10 yuan													
E	Medical xaminer		resulting in death) Due to (or as a co	nsequence of):		0 007 0== 3	`		- Control							
		ner	if any, leading to immediate Due to (or as a co	molvels insequence of):	undernia											
cuted	nd transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events													
Oe exe	physician and as the burial-transit	dical E	resulting in death) Last Due to (or as a co	nsequence of):												
3760 ficate b	g phys as the	- w -	d													
Box 687	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Completed by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnant at time of the past 12 months? 4 ☐ Pregnant at time of the past 12 months? 4 ☐ Pregnant at time of the past 12 months?	Fetal death 3	Ectopic pregnancy Other (specify)	<i></i>		23d. Date Mont	e of delivery nth Day Year							
, P.O.	igned by	by Pi	Part II. Other significant conditions contributing to death but r	ot resulting in the u	nderlying cause give	en in Part I.			oute to the cause of death?							
ords	been s	letec	1,700 9011120110 00	o zwie			24a. Was a		ere autopsy findings available							
Sec.	ate has	omo					autop	rmed? pr	ior to completion of cause of eath? Yes 2 No							
tal	ector, I	Be	25. Was case referred to medical examiner?			ice of Death (Check										
of Vi	r this ceral dir	e: To	1 ☐ Inpatient 27. Manner of Death 28a. Date of injury	2 ER/Outpatier 28b. Time of	othe 28c. Injury	4 L Nursing Ho		ence 6 Other								
on (or: Afte	ficat	1 ☐ Natural 5 ☐ Pending (Month, Day, Ye 2 ☐ Accident Investigation	ear) injury	M 1 □	Yes 2 No										
Division of Vital Records,	s after de	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury building, etc. (S	At home, farm, stre pecify)	eet, factory, office		28f. Location (S City or Tow		or Rural Route Number,							
Hospit	in 24 hour he Funera pletely fill	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my 2 Medical Examiner: On the basis of exam only one) 3 Certifying Nurse Practitioner: To the best of my	ination and/or invest	igation, in my opinio	n, death occurred at	the time, date a	nd place, and due t	to the cause(s) and manner stated.							
- P	To th		29b. Signature and title of certifier They G. Wenn	elo, m.	29c. License	number 5384		29d. Date signed	(Month, Day, Year)							
Ú	TO		30. Name and address of person who completed cause of death RUDWEY A. WENRICH, M.D. 13	(Item 23a) (Type, F	Print) SION ST	SALIC	BURY	mD 218	304							
	Stat Registra		31. Date filed (Month, Day, Year) JAN 10 2012 32. Registrar's	46 S. DIVI	nke											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ BLANCHE ELIZABETH TRUSTY JANUARY 2012 3:40 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HAVRE DE GRACE HARFORD HARFORD MEMORIAL HOSPITAL 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Year)931 JAN 29, 250-68-3179 80 **Director** NEW YORK Usual Residence of Decedent or 28a-f show notified at show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director HARFORD 1 Yes 2 No MARYLAND HAVRE DE GRACE 10e. Street and Number 10f. Zip Code rms 23a or 10g. Citizen of What Country? Funeral 850 ERIE STREET 21078 UNITED STATES hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian "natural", or iten edical Examiner Armed Force Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: BLACK Completed 3 X Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' ury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) NURSES ASSISTANT VA HOSPITAL 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ WALTER EDWARD JAUDON ROSETIA SAWYER 19a. Informant's Name/Relationship (Type, Print) 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LEAH WARFIELD / DAUGHTER 553 HALL COURT, HAVRE DE GRACE, MARYLAND 21078 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or HARFORD MEMORIAL GRD 1/16/12 ABERDEEN, MARYLAND 4 Donation 5 Other (Specify) 2. Name and Address of Facility
LISA SCOTT FUNERAL HOME,
552 LEWIS STREET, HAVRE Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the prode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate VENLEY IA Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Physician/Medical Examiner Due to for as a consequence of the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death n signed by the a Id be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an has death? Hospital or Attending Physician; The 124 hours after death. Funeral Director: After this certificate P 1 Yes 2 Vo Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2**154** No Other 1 🗌 Yes ၉ 1 Appatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Watural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident D Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying Nurse Practioner, To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 29b. Signature and title of certifier 29c. License 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year

Registrar's Signature

			For State Registrar		51	ate or ivi	arylario		artment of t tificate of t		ariu iv		gierie Reg. No.	201	2	01806	
	Physicia	n/	Decedent's Name Manager			n e 1 1	1		-			2. Date of De Month		012 Yea	r	3. Time of Death	
Lane	Medic Examin	al	Martin 4a. Facility Name (if	Harw not institution		Fickel:	<u> </u>		4b. City, Town, o	r Location o	of Death	JAN (O12 County of De	eath	0730 ^M	
- Marie	Examili	CI	Shady G				pital		Rockvi1					ntgome			
4	Funeral		5. Social Security N		6. Sex			st birthday)	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da			Birthpl Co <i>untr</i>	ace (State or Foreign	
	Director		128-07-8 Usual Residence		1 X) M 2	PLF	92	Yrs.				NOV 30,	191	9		NY	
	land f shov d at	tor	10a. State	10b. Count	у		10c. City	, Town or Loc	cation		_				10	Od. Inside City Limits	
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	ith the	ral	11609 Sc		Leaf (Gircle		10f. Zip Code 20876			zen of What ted St						
	tems er mu	Funeral Director	11. Marital Status		12. Wa	as Decedent I	Ever in U.S	. 13. V	Vas Decedent of H	lispanic Ori	gin? (Spe	cify Yes or No-		4. Race - Ar	nerica	ın Indian,	
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	l by	1 Never Marr			med Forces? Yes 2 Yes, Give			Yes, specify Cub			Rican, etc.)	5	Black, Wi Specify:			
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Maryland	be filed rental Hygred oth	To B	17. Father's Name (Martin H			211. S1	r.			UNAV		(First, Middle, RT.F.	Maiden S	urname)			
aryl	should and Me is mar raumati	1	19a. Informant's Na				19b. Mailing Address (Street and Number or Rural Route Number, City or Town									ode)	
	alth a m 27 is		Robert H	I. Tic	kell /	son		11609	Scar1et	Leaf	Cir	cle, Ge	rman	town,	MD	20876	
Baltimore,	permit. Page 1 and 2 si Department of Health a Important: If item 27 is any injury or other tra once,		20a. Method of Disp 1 D Burial 2	X Cremation	n 3 🗆 Remov	al from State		ace of Dispo emetery, cren	sition (Name of natory or other pla			ate	20c. Lo	cation - City	or Tov	vn, State	
Itim	permit. Page Department of Important: If any injury or once,		4 ☐ Donation 21. Signature of Fu				At1		Cremato			/2012		Burn	ie,	MD	
Ba	permit Depar Impor any in	ļ	21. Signature of Full	neral Service	Licensee	N	10095	6 T	Name and Addre hibadeau Park Av	Mort	uary Gai	Servic	e, p	.a.	77		
			23a. Part 1. Enter t	he disease, o	or complication only one caus	ns that cause	d the death							<u> </u>		Approximate Interval Between	
pin	Physician/		Immediate Cause (disease or condition	Final				iecondo	ry to in	fecte	dul	ier			5	Onset and Death 2 weeks	
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		ner	Sequentially list co if any, leading to in	nmediate	b. —	Due to (or as	a consequ	ence of):	514	10 10	~(P				1	14001(107)	
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	icate be executed I physician and Is the burial-transit	alE	resulting in death) I	Last		Due to (or as	a consequ	ence of):									
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89	eath certifica attending pl I for use as t		IF FEMALE: 23b. Was decedent		23c. If y	yes, outcome	of pregnar	ncy	Ectopic pregnan	CV			2	3d. Date of	delivery		
Вох	death he att	Physician/N	in the past 12 in the past 12 in the past 12 in	□ No	4 [Pregnant a			Other (specify)					Month	ĺ	Day Year	
P.O.	es that the dea igned by the a be detached i	/ Ph	Part II. Other signif		ions contribut	ing to death t	out not resu	ulting in the u	nderlying cause g	ven in Part	l.	23e. Did to	obacco us	se contribute	to the	e cause of death?	
S, F	uires th	ed by										1 🗆	Yes 2	□ No 3 □	Prob	ably 4 V Unknown	
orc	iw require as been sig 2 should I	plet										24a. Was		24b. Were	autop	sy findings available npletion of cause of	
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ital	ysician: T nis certifica I director, p	Be	25. Was case referre	_	l Hospita	ıl:			Oth	lace of Dea							
of V	ding Phys h. After this funeral di	e: To	1 Yes 2 27. Manner of Death	∡ No h	28	a. Date of inju	iry	ER/Outpatien 28b. Time of	t 3 DOA 28c. Inju	4 ∐ Nı		me 5 Resident			ecify)		
ou c	ath. r: Afte	icat	1 Anatural 2 Accident		tigation	(Month, Da	y, Year)	injury	wor	k̂?]Yes 2 □	- 1		, ,				
Division of Vital Records,	or Atte fter de irrecto	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 ∐ Coule deter	mined 286	e. Place of Injude			eet, factory, office			28f. Location (\$ City or Tov		Number or i	Rural I	Route Number,	
Ö	ours a ours a leral D	To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner to the best of my knowledge, death occurred at the time, date and place and place at the time to the cause (s) and the best of my knowledge (s) and the best of my kn											d manner as	state	d.		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and prompletely filled in by the funeral director, page 2 should be detached for use as the burnal-transit	Medical	(Check 2	Medical	Examiner: On	the basis of e	xamination	and/or invest		on, death or	curred at	the time, date a	and place,	and due to th	ne caus	se(s) and manner stated.	
	A LA SIE		29b. Signature and	title of certifi	er				29c. Licens	e number				signed (Mo			
	iri		Mi	me V	Mus	an !	MD	00.7		70	144		Jar	nowy	5	, 2012	
			30. Name and address	ess of persor Wrrqv		ed cause of d	eath (Item Medic	zsa) (Type, P	nter Du	ive, 1	200K	ville, 1	Mary	land	20	450	
	Sta		31. Date filed (Monta	h, Day, Year)	0540	32. Registr	ar's Signat	re be	nter Du			/			-		
	Registra	ir	JF	IN 10	4014	Lexun	U P	. 17	-								

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death , 2012 Year Physician/ 21:05 P^{M} January 6, Thomas Sheila Elaine Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Southern Maryland Hospital Prince George's Clinton If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 🗗 F Director 579-76-2381 56 Yrs Sept. 2, 1955 DC Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location Director 1 X Yes 2 No Suitland Maryland Prince George's 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 3611 Silver Park Drive 20746 United States . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. 1 X Never Married 2 Married ð Maryland 21215-0036 Black 1 Yes 2 No Specify. If Yes, Give Specify: Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) 12th College (1-4 or 5+) Private Sales Clerk Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Ruth Murphy Virgil Clark Thomas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $\,\,20746$ 19a. Informant's Name/Relationship (Type, Print) 3611 Silver Park Drive # 204 Suitland, Maryland Cynthia R. Thomas - Sister Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition January 13, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Suitland, Maryland 2012 4 ☐ Donation 5 ☐ Other (Specify) Lincoln 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stewart Funeral Home, Dom 20019 4001 Benning Road NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Obstructive Pulmonon Physician. honic disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine to for as a consequence of burial-tran and Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be to the hours after death.
 Funeral Director: After this certificate has been signed by the attending physicis. Box 68760 IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death signed by the at Id be detached for ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes 2 funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **D** No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certificate: iniury Natural 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 🛂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse within 2 To the I only one 29b. Signature ar 29d. Date signed 20735 23a) (Type, Print) erson who 7503 Surratts Rd. Clinton, Md.

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . 2<u>012</u> Physician/ Month Jan 11 0330 Twiga Millard Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Allegany Golden Living Center Cumberland If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD **Funeral** Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day Ye. Min **Director** 217-10-1388 94 or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Cumberland MD Allegany 1 □XYes 2 □ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 23a Funeral 720 White Avenue 21502 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, ō 2 **X**lo 1 Never Married 2 X Married Completed by 72 hours after 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: "natural" 3 🗌 Widowed 4 🗌 Divorced white Year or Dates the Medical 15, Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) People's Life Insurance <u>Insurance salesperson</u> permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mary Shryock Carl Twigg 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Mildred Twigg 720 White Avenue Cumberland MD 21502 wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Forest Glen Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 1/14/2012 WV Green Spring Conation 5 Other (Specify) 22. Name and Address of Facility
Scarpelli Funeral Home, PA Signature Fuperal Service Lie 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ ord ha 0 YNS Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): that the death certificate be executed the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Year been signed by the a should be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 No 2 No __ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d, Describe how injury occurred Natural 5 Pending 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Yur Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) 10033280 Jan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) "Ave. Ste. 101 Cumberland, MD 21502 Gru M.D. 625 Kent 31. Date filed (Month, Day, Year) Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

Box 68760

P.0.

Records,

Division of Vital

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			State Registrar		Cer	tificate of I	Death	R	eg. No. 201	2 01809				
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122	Funeral		Social Security Number		e (In yrs. last birthday)	If Under 1 Year Months Days		8. Date of Birth						
	Director		703-05-3609 Usual Residence of Decedent	1 🕱 M 2 🗆 F	91 Yrs.	0, 1920	Birthplace (State or Foreign Country)							
	land show dat	ţō	10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Limits				
	Mary 28a-f	Director		legany	Cui	mberland				1 ☐XYes 2 ☐ No				
	is filed within 72 hours after death with the Maryland tal Hygiene. ed other than "hatural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ral	10e. Street and Number 512 Winifred	Pood		10f. Zip Code	21502	1	l 0g. Citizen of What	t Country? SA				
	leath v items er mu	Funeral	11. Marital Status	12. Was Decedent B		Was Decedent of H	dispanic Origin? (Spean, Mexican, Puerto	ecify Yes or No-	14, Race - A	American Indian,				
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Maryland	12 shouth and 27 is rr		19a. Informant's Name/Relations Lenora Turner	hip (Type, Print) wife		ng Address (Street 2, Box 1	and Number or Rura	al Route Number, Key		, Zip Code) WV 26726				
Baltimore,			20a. Method of Disposition 1 X Burial 2 Cremation	3 Removal from State	20b. Place of Dispo	sition (Name of natory or other place	ce) [Date	20c. Location - City	or Town, State				
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Bal	permit. Departr Imports any inju		21. ignature of Funeral Service	rensee	22		ess of Eacility Delli Funeral H		and MD 0150	22				
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Sec. of the	Medical Examiner		resulting in death) Due to (or as a consequence of):											
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Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate k within 24 hours after death. On the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the local page.	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live Birth	of pregnancy 2 Fetal death 3	Ectopic pregnanc	cy		23d. Date of	,				
. Bo	e deat the at ched fo	ıysici	1 Yes 2 No 9 Unknown	4 ☐ Pregnant a 9 ☐ Unknown	t time of death 5	Other (specify)			Month	Day Year				
Division of Vital Records, P.O.	that th ned by e detai	by Pr	Part II. Other significant condition	ons contributing to death b	ut not resulting in the u	nderlying cause gi	ven in Part I.	23e. Did tob	pacco use contribute	e to the cause of death?				
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SCO!	has be	Completed						24a. Was ar autops	y prior	autopsy findings available to completion of cause of				
Ä	sician: The law r certificate has b lirector, page 2 s		25. Was case referred to medical		-	26 P	lace of Death (Check	perform 1 \(\sum \text{Yes} \(2\)	No 1	Yes 2 □ No				
Vita	Physicia this cert ral direct	To Be	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	ent 2 ER/Outpatien	Oth			nce 6 🗆 Other (Sp	pecify)				
ιof	ling PI 1. After the		27. Manner of Death 1 ☑ Natural 5 ☐ Pendir	28a. Date of injur (Month, Day	y 28b. Time of injury	work	y at '		w injury occurred					
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Divi	tal or vrs after al Dire		4 - Hornicide detern	building, etc	. (Specify)			City or Town						
	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	(Check 2 L Medical E	Physician: To the best of Examiner: On the basis of ex	kamination and/or invest	igation, in my opinie	on, death occurred at	the time, date and	d place, and due to the	he cause(s) and manner stated.				
	To the within to the comple		only one) 3 L Certifying 29b. Signature and title of certifie	Nurse Practitioner: To the	best of my knowledge,	29c Licensi	e number	2	e cause(s) and manne 9d. Date signed (Mo					
	10 01			hy am		100	03328	Ն	Jan 15	5,2011				
	10 31.		30. Name and address of person		eath (Item 23a) (Type, P	rint)	1010.	hanla	200 60	21202				
	Stat	e	31. Date filed (Month, Day, Year)	2 M.D. 625	Signature	UC. 216.	101 aum	De lar	<u> </u>	alset				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jan 5, Physician/ Allene Turner E. 11:30 a M Medical y, Town, or Location of Death **Clinton** 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death Southern MD Hospital If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 01-27-1926 Director 1 □ M 2 🔀 F 85 Yrs. Georgia 28a-f show 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Funeral Director Rd. MD Charles Bryans X Yes 2 No 10f. Zip Code 20616 10e. Street and Number 10g. Citizen of What Country? 5276 Greenville Dr. USA should be filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 X No Yes, specify Cuban, Mexican, Puerto Rican, etc. Completed by Black. White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black If Yes, Give 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Cosmetologist Private 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Willie Edmondson Aleathia Wright Walter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5276 Greenville Dr. Bryans Rd., MD 20616 Page 1 and 2 sh tment of Health a tant: If item 27 is Allene Gordon/Granddaughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of F
Important: If ite
any injury or oth Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington Nat'l Cem. 1-19-2012 Arlington, VA 21. Signature of Funeral Service Licensee 22. Name and Address of FacilitRonald Taylor II FH 10583 Middleport Ln. White PLains, MD 20695 23a. Part 1. Enter the disease, or complications that caushock, or heart failure. List only one cause, on each ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, DIQUASCUTAL DI Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) as a consequence of **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 🔀 No Pregnant at time of death ed by the a Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 KNo 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? 2 No 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2X No 1 🗹 Inpatient 2 🗌 ER/Outpatient 3 🔲 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury 5 Pending 124 hours after death. e Funeral Director: Aff eletely filled in by the fu 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical 29a. Certifier 1 📈 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. DED LINE CENTER WALTER, MO State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 For State Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JANUAR Medical Name (if not institution, give street and number) Town, or Location of Death Examiner OK INS 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign rs. last birthday **Funeral Director** 1**X** M 2 □ F August 13, 1948 63 Pennsylvania or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 2 should be filed within 72 hours after death with the Maryland or items 23a or 28a-f sho miner must be notified at Director PA 1 Yes 2X No Perry Oliver Township Newport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1090 Trout Ave. 17074 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. 1 Never Married 2 X Married Completed by 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: "natural", Specify: White 3 Divorced other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Penn DOT Materials Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers is marked or မ William Trout Martha M. Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once, Esther M. Trout, Wife 1090 Trout Ave. Newport, PA 17074 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🔀 Removal from State cemetery, crematory or other place, 1/14/2012 Newport Cemetery Newport, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JJ Hartenstein Mortuary, Signature of Funeral Service Licenses 17349 24 N. Second St. New Freedom, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. vendu Onset and Death Immediate Cause (Final Ph sician/ 0 disease or condition Medical resulting in death) xaminer Sequentially list conditions, Physician/Medical Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last use as the burial-trar attending physician and Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year 4 Pregnant at time of death 9 Unknown Yes 2 No the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director; After this certificate has page 2 autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Yes 2 X No 1 XInpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury 28h Time of 28c. Injury at work? 28d. Describe how injury occurred Natural Accident (Month, Day, Year) 5 Pending 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier 📉 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier KES-000 JANUARY 9, 2012 600 N. WOLFE St, BALL, MORE, MD 12128, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Date filed (Month, Day, Year State

DHMH 17 Rev 06-2011

Registrar

AN 2 3 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Christine Lorraine Victor 0330 M 2012 Medical Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** REGIONAL UICOMI CO ENINSHLA SALISBULA MEDICAL ial Security Number If Under Year If Under 8 Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days (Month, Day, Year) **Director** 218-58-0346 1 □ M 2**X** F -18 - 1953MD 58 ms 23a or 28a-f show must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Wicomico Salisbury 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ıral", or items 23a Examiner must be Funeral 21804 USA 1019 Adams Ave, Apt F death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2X Married ☐ Yes 2 🔀 No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify. is marked other than "natural", SpeciBlack 3 Widowed 4 Divorced Completed Year or Dates traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Shore Up, Inc! Head Start Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Rosie E. Asby Eddie Coston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ortant: If item 27 injury or other tra 1019 Adams Ave, Apt F, Salisbury, MD 21804 John Victor/Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name_o 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date cemetery, crematory or other had 1 Burial 2 XCremation 3 Removal from State 4 Donation 5 Other (Specify) Cremation, 1-10-2012 Dover, DE Signature Funeral Service Licensee 22. Name and Address of Facility Bennie Smith 917 W. Isabella St. Funeral Home Salisbury 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Onset and Death Immediate Cause (Final accident Physician/ 1 con vascular disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami and -tran Due to (or as a consequence of) resulting in death) Last physician s the burial Medical law requires that the death certificate be Box 68760 as attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Year Pregnant at time of death 2 No 9 ☐ Unknown g 🗌 Unknown Records, P.O. ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Jas autopsy performed? certificate ha or Attending Physician: The 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Tes 2 No 읻 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 124 hours after death.

Funeral Director: Aft letely filled in by the fu 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Funer completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29c. License number 00071277 1.12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MILFORD ST, STESDYB SAMSBURY MD 2804 AREEN AHMED 106 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Myrtle Vacirca January 2012 0930 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1890 Red Toad Road Port Deposit Cecil Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 060-16-0260 **Director** 1 □ M 2 🔀 F 95 Nov. 29, 1916 Massachusetts Usual Residence of Decedent 28a-f show 10b. County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a, State 10c. City, Town or Location Director Maryland Cecil 1 Yes 2X No Port Deposit 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 1890 Red Toad Road 21904 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☒ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give 1943-45 1 ☐ Yes 2 X No Specify: Completed 3 🛚 Widowed 4 🗆 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 th and Menta! Hygiene. It is marked other than "r New York City Elementary/Secondary (0-12) College (1-4 or 5+) New York 5+ Social Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Vincenzo Vacirca Clara Palumbo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Dylan J. Alliata (son) 6018 Goldenrod Court, Alexandria, Virginia 22310 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) _20c. Location - City or Town, State West Chester Date 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State injury or R.A.Ferris & Co., Inc. 01/09/12 4 Donation 5 Other (Specify) Pennsylvania 21. Signature of Funeral Service License 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, any i Chomes M. tattimon Perryville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ pra disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to minediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of, or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): -burial-Physician/Medical Box 68760 as the IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year Yes 2 L P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe Records, 1 Yes 2 No 3 Probably 4 Unknown funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 No Yes 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? Nieco House 1 Yes 2 1 No Other: မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DQA 4 Nursing Home 5 Residence 6 Pother this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes hours after death Accident Investigation 2 ☐ Accident
3 ☐ Suicide
4 ☐ Homicide filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a Hospital Medical ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check Cortifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 4 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Jan. 2012 George William VIRTS 4:40 p M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Autumn Assisted Living Washington Hagerstown 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** If Und Year If Under 24 Hrs. Months Hours Min **Director** 1 🛛 M 2 🗆 F 217-16-2618 91 March 18 1920 West Virginia show 10a. State 10b. County with the Maryland must be notified at 10c. City. Town or Location Director 28a-f 1 Yes 2 No Maryland Washington Hagerstown o. 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Autumn Assisted Living Funeral "natural", or items 23a 310 Cameo Drive 21742 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items: any injury or other traumatic event, the Medical Examiner musonce. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ģ 1 Never Married 2 Married X Yes Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify White Completed 3 X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Labor Railroad Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ George Milton Virts Donna Isabell Birkitt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Hamilton - Daughter Box 583 Funkstown, Maryland 21734 0. 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Broadfording Ch. Cem. 1/13/2012 Hagerstown, Maryland 21. Signature - Uneral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph_sician/ disease or condition mi Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to (or as a consequence sty: Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical law equires that the death certificate be P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No for Month Day Year Pregnant at time of death heen signed by the a should be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Pecords, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an te has hage 2 s perform Yes 2 N 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Hospital Other: မြ 1 Yes 2 100 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) e Funeral Certifying Physician: To the best 29a. Certifier my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis Certifying Nurse Produtionar: (Check examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I the best of my knowledge death one ed at the thire. Date and place, and due to the cause(s) and marrier as stated 29b. Signati re and title of certifie 62 30. Name and address of person who completed caus of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 201^Y2ar January Lloyd Owen Wenger, Jr. 1:55 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7450 Sedwick Court Calvert Leonard Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08/16/1946 **Funeral** Age (In vrs. last birthday) 9. Birthplace (State or Foreign Days 1 ⅓ M 2 □ F Country) Washington, DC Director <u>212-48-9022</u> 65 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown printy or other traumatic event, the Madical Examiner must be notitified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 🗌 Yes 2 🛂 No MD Calvert St. Leonard 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7450 Sedwick Court 20685 United States 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 2 Married 1 Yes : Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates. 1966-1972 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Engineer Nuclear Power Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Lloyd Owen Wenger, Sr. Pauline Celeste Throop 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Kathie Jean Wenger</u> / Wife 7450 Sedwick Court, St. Leonard, MD 20685 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ⅓ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) MD <u>Veterans</u> Cemetery 01/13/2012 Cheltanham, Maryland 21. Signature of Funeral Service Lice 22. Name and Address of Facility Rausch Funeral Home, P.A. P.O. Box 600, Lusby, MD 20657 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph_sician/ Stage IV Danciewhi Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter ordenying Cause (Disease or iinjury Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Month Year 9 ☐ Unknown Unknown this certificate has been signed by ral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No ျှ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred eral Director: After filled in by the funer Natural 5 Pending 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or Att within 24 hours after of To the Funeral Direct determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 56024 January 9, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Yea

32. Registra s Signature

Kenneth L. Abbott, MD 110 Hospital Road, Suite 110, Prince Frederick, MD 20678

3. parked

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2012 Anna M. Wantz January 11:45 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Dacota Broad Creek Assisted Living Harkord Whiteford Writte Burker

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Days | Hours | Min. | Malf 30, 9. Birthplace (State or Foreign Country)
Pennsylvania 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 21 F 166-16-1726 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examinating at 1 ☐ Yes 2 No Director MD Harkord Havre de Grace 10g. Citizen of What Country? 10e. Street and Number 3816 Moxley Road 21078 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 _Yes 2 1 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 **X**No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home of Health and Mental Hygid I item 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Zenone Edna Finley ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Peggy Creel (Daughter) 3816 Moxley Road, Havre de Grace, Maryland 21078 D partment of Heal Important: If item 2 any injury or other once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem.Park 01/07/2012 Elkridge, Maryland 22. Name and Address of Facility Zellman Funcial Home, P.A. agnature of Funeral Service Licensee 123 S. Washington St., Havre de Grace Approximate Interval Between Onset and Death 3a. Part1. Enter the disease, or complice shock, or heart failure. List ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line Immediate Cause (Final CALKIR disease or condition resulting in death) Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 □Yes 2 🗷 No been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 21 No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 ☐ Nursing Home Statement 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ 🖔 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred **V** ■ Natural 5 Pending ours after death.

neral Director: At filled in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral to completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2000 48050 Coll 1/6/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print MO 21001 Aberdeen 15 S. Palke St 10 Shukla, Prashant 31. Date filed (Month, egistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Merical Hygiene 2 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Uvi Wona Month 11: 28 PM January 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death University of Maryland Medical Center Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral **Director** 573-81-3265 1 X M 2 🗆 F 01/24/1965 46 Hong Kong ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Silver Spring 1 🗆 Yes 2 🗓 No Maryland Montgomery 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 2609 Summer Hill Court 20904 U.S.A. 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗶 No
If Yes, Give Black, White, etc. 1 Never Married 2 X Married ģ Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Asian Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Mathematician Federal Government and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Wai Ying Ko Wan Wong 19a. Informant's Name/Relationship (Type, Print, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 2609 Summer Hill Court, Silver Spring, MD 20904 Health tem 27 I-Chen Lin - Spouse permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 1 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) ☐ Burial 2 X Cremation 3 ☐ Removal from State Ft. Lincoln Crematory 01/16/2012 | Brentwood, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral, Service Licens 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Dneumonia Medical resulting in death) Examiner leukemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 as IF FEMALE: nse yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Month 4 Pregnant g Unknown Pregnant at time of death Yes 2 No 1 | Yes 2 L g | Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, the Hospital or Attending Physician: The law requires 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 🗆 No 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) examiner? 2 XNo ည 1 ≤ Inpatient 2 □ ER/Outpatient 3 □ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending injury Division s after death.

I Director: Af 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number AU4176435W101570 29d. Date signed (Month, Day, Year) January 2, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greene St., Baltimore, MD 21201 Betrany Weiler MD, 5. State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 3, 2012 ear Jack Harold Walker 10:40 A.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Northampton Manor Frederick 8. Date of Birth (Month, Day, Year If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Davs Hours 91 Director 247-16-7617 **1XX**M 2 □ F May 22, 1920 South Carolina Usual Residence of Deced or 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. Count Director Maryland Frederick Frederick 1 Yes 2X No or 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be USA Funeral 21703 6441 Jefferson Pike 27 is marked other than "natural", or items traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian 11. Marital Status Black White etc. 1X Yes 2 ☐ No If Yes, Give 1939 þ 1 Never Married 2 Married within 72 hours after white 1 ☐ Yes 2X No Specify 3 Widowed 4 Divorced 1969 Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) U. S. Navy Gunnery instructor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F Julia Young Harry Grady Walker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Walker - Son permit. Page 1 and 2 st Department of Health a Important; If item 27 is any injury or other tran 2 Monocacy Court, Walkersville, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 T Cremation 3 Removal from State 1-6-2012 Stauffer Crematory Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home Maron 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 40 cande Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Cue to lot as a compuence of) that the death certificate be executed the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: nse 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ____ ŏ in the past 12 months? 1 Yes 2 L 9 Unknown Yes 2 No ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performs 1 Yes 2 No Yes 2 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 2 No 1 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA ျပ 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) s after death.

I Director: After this of in by the funeral d 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending Natural 5 Pending work 1 Yes 2 No ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 To the F only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 D43091 1-5-2012

Registrar

State

30. Name and address of person who complete

6

31. Date filed (Month)

21215-0036

Baltimore, Maryland

Box 68760

P.O.

Records,

Division of Vital

32. Registrar's Signature

Tou House Ave, Rederich, MO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 State
Registrar Amend#24a PerPhys PGC1-12-12 Certificate of Death 2. Date of Death 3. Time of Death Montb 1 Physician/ Day 09 1:22 Т Ам White James Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 9300 Allentown Rd Prince George's Fort Washington Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 09-02-1949 62 Virginia 227 62 9390 Director Usual Residence of Decedent show 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits notified at Funeral Director MD Prince George's Fort Washington 28a-f 1 Yes 2 No 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r 9300 Allentown Rd 20744 USA permit. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 19 19 73 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc ö þ 1 Never Married 2 Married Saltimore, Maryland 21215-0036 **Black** 1 ☐ Yes 2 No Specify. Specify "natural" Completed 3 Divorced 4 Divorced Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry of Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Bus Driver Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Hattie Giles Raymond White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9300 Allentown Rd Ft Washington, MD 20744 Department of Health ar Important; If item 27 is any injury or other trau Verndel White - wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Bethel Cemetery 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 01/14/12 Alexandria, VA 21. Signature of Funeral Service I 22. Name and Address of Facility Greene Funeral Home 814 Franklin St Alexandria VA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Examiner Due to (or as a consequence of Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of. and I-transit that initiated events resulting in death) Last Due to (or as a consequence of): burialattending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Day Year n signed by the a 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 XYes 2 □ No 3 □ Probably 4 □ Unknown een 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law 24 hours after death.
Funeral Director: After this certificate has b autopsy performe Yes 2 XN 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) the funeral director, Be examiner? Hospital Other: 2 No 1 🗌 Yes မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗶 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Matural 5 Pending injury 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number determined building, etc. (Specify) City or Town, State) 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature an 29d. Date signed (Month, Day, Year) 1.10.12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 333 WHEL BRANCH 6104 OLD AVE State JAN 1 2 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death January 5 Day 2012 Year Physician/ 7:30 Ам Annie Watson Medical 4a. Facility Name (if not institution, give street and number) 4b City Town or Location of Death 4c. County of Death **Examiner** Prince George's 9925 Elm Street Lanham Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Ye 1 □ M 2 🕇 F Months Days Hours Min. 1920 91 Yrs Virginia **Director** 577-28-1051 Aug. Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10d. Inside City Limits 10c. City, Town or Location must be notified at Director 1 X Yes 2 No Maryland Prince George's Lanham ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 20706 9925 Elm Street United States death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. 0 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after Specify: American African If Yes, Give Year or Dates. 1 Yes 2 No Specify: "natural" Completed 3 X Widowed 4 ☐ Divorced the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Services General life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 9th Custodian Administration Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Estelle Moore Dudley Lane 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9923 Elm Street 20706 Lanham, Maryland Sarah Savoy - Daughter 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of January 14 cemetery, crematory or other place) 1 3 Burial 2 Cremation 3 Removal from State Suitland, Maryland 2012 4 Donation 5 Other (Specify) Lincoln 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, Din 4001 Benning Road NE Washington, DC 20019 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Cerebrovascular Insufficiency **Medical** Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of, Examir Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death signed by the a d be detached fe g Unknown g 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy page perform death? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 X No Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 28d. Describe how injury occurred injury 1 X Natural 5 Pending To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft completed filled in by the fur М Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) D23743 January 10, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Martin D. Weltz, MD

e filed (Month, Day, Year) JAN 1 2 2012

32. Registrar

7525 Greenway Center Drive Suite 205

Greenbelt, Md.

20770

amended item #20B/wchd/1-6-12/map Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day 2012/ear Physician/ Robin Louis Whaley 01 2011 1154 M Medical 4a. Facility Name (if not institution, give street and number 4c. County of Death Examiner 4b City Town or Location of Death REGIONAL MEDICAL SAVISBULA INIJSULA 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Min (Month, Day, Year) Days Director 52-5842 1 💢 M 2 🗆 F 44 8-8-1967 Usual Residence of Decedent MD 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland at 10c. City. Town or Location Director 10d. Inside City Limits or 28a-f st notified 1 Yes X No MD Worcester Berlin or 10f. Zip Code 10g. Citizen of What Country? pe Funeral 23a must ! 9100 Reedy Cove Drive, Apt 107 21811 USA ral", or items 2 Examiner mus 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc. Completed by 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Speciallack "natural", 3 Widowed 4 Divorced Health and Mental Hygiene. tem 27 is marked other than "natur other traumatic event, the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Atlantic Gen Hosp 11 Dietary Aide Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Paul Whaley Ethel Lee Turner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) other <u>Sandra L. Merrill/Sister</u> 822 White Oaks Ct, Pocomoke, MD 21851 20a. Method of Disposition Department of H Important: If ite any injury or ot 20c. Location - City or Town, State Showed isposite Niverence Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) vary Cemetery 1-7-2012 Berlin, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Bennie Smith Funeral Home 917 W. Isabella St. Lu Salisbury, MD 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ESRD Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner YTERTENSION DIADETES AND Sequentially list conditions, if an .. leadin . to immediate cause. Enter Underlying Examiner AS CVD Cause (Disease or injury that initiated events resulting in death) Last and use as the burial-trar Due to (or as a consequence of) nding physician Physician/Medical death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery atter 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No for Day the P.O. ed by the Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. signed | d be det 23e. Did tobacco use contribute to the cause of death? by Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autonsy perform certificate 1 Yes 2 No Yes Hospital or Attending Physician: Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral c Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at After 28d. Describe how injury occurred 1 Natural work?
1 \(\sum \) Yes 2 \(\sum \) No 5 Pending injury within 24 hours after death.

To the Funeral Director: A completely filled in by the fi Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month Day, Year) 30. Name and address of person who completed days of death (Item 23a) (Type, Print) D58689 01 , 100 F. CALROY ST., SALISBURY, MD SWIERKOSZ State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	Funeral		5. Social Security		. Sex		ge (In yrs.	last birthday)	If Under	1 Year	If Under		8. Date of Birt (Month, Day		ashin		ice (State o	or Foreign
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	72 hours after death with the Maryland natural', or Itams 23a or 28a-1 show ifted Examinar must be notified at	by Funeral Director	11. Marital Status	LIUIAN L	12. V	Vas Decedent	Ever in U	.S. 13.	l		spanic Ori	gin? (Sp	ecify Yes or No- Rican, etc.)		J.S.A 4. Race		n Indian,	
9	after (or Itar	Fun		ried 2 Married	1 1	med Forces			_				Rican, etc.)			White, e	tc.	
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an	d be antal cad o	o Be		oliver W									Smith		, , , , , , , , , , , , , , , , , , , ,			
Maryland	shoul nd Me mark	2	19a. Informant's N			Print)		19b. Maili	ng Address	(Street a			al Route Numbe	r, City or	Town, Sta	te, Zip (Code)	
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deportment of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Itams 23a or 28a-f show any nivry or other traumetic evant. The Medical Examinational be notified at once.		21. Signature of F	uneral Service Lic	ensage				. Name an		-82		est Hav					
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	/Medical Examiner		resulting in death)	- 1		Due to (or as	,	uence of):			. A							
		<u>.</u>	immediate cause (Final disease or condition resulting in death) a. Levolvever Accident Due to (or as a consequence of): Hiteus selve by Conductors Duslan Due to (or as a consequence of):										1 0	EARS				
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	To the Hospital or Attanding Physicien: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one)	Certifying	aminer: (n: To the best On the basis o and manner st	f examinal	wledge, deatl tion and/or in	occurred avestigation,	at the tim in my op	e, date an inion, dea	d place, th occurr	and due to the coed at the time, o	ause(s) a late and	and manne place, and	or as sta due to t	ted. he cause(s	;)
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a	Al Mi		30. Name and add	ress of person wh	o comp e	ted cause of	- '	1 23а) (Туре,	Print)			ı			,			
	1 1.		741		2000 11	r 11	90		AMA	R	OMO	1+	Mansi	NWU	M	0 3	2174	2
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jan. 2. Day 2012 ear 10:00AM Joseph Max Zimmer Jr. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Worcester 8623 Saddle Creek Drive Berlin 6. Sex 1 ♣ M 2 ☐ F 5. Social Security Number 7. Age (In vrs. last hirthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Min. 7 _1/2 nIh_Day. 9e4r)2 69 **Director** 218-40-7516 Yrs. MD Usual Residence of Decedent 28a-f show 10a. State 10b. County the Maryland 10c. City, Town or Location Director 10d. Inside City Limits notified Berlin 1 Yes 2 XNo MD Worcester 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? ems 23a or r must be Funeral Page 1 and 2 should be filed within 72 hours after death with 8623 Saddle Creek Drive 21811 USA items "natural", or item edical Examiner r Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. white Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) Contracting Entrepreneur event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) th and Mental H

27 is marked of
traumatic ever ည Anna Margaret Vogtmann Joseph Max Zimmer Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau once. Sheila Zimmer- Wife 8623 Saddle Creek Dr. Berlin, MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
First State Crem. 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 1 - 3 - 12Millsboro, DE 4 Donation 5 Other (Specify) f Funeral Service 22. Name and Address of Facility Burbage Funeral Home William Street Berlin, MD 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury -transit and that initiated events resulting in death) Last use as the burialphysician Physician/Medical or Attending Physician; The law requires that the death certificate be P.O. Box 68760 the attending IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 - Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month be detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has page 2 s autopsy perform eral Director: After this certificate filled in by the funeral director, pag Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of De Itl 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred Natural 2 Accident 5 Pending death. Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. after determined City or Town, State) within 24 hours a Hospital Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and 29d. Date signed (Month, Day, Year,

DHMH 17 Rev 7/2009

State Registrar s of per

JAN 03

31. Date filed (Month, Day,

on who completed cause of death (Item 23a) (Type,

32 Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 3:40 BOW 01 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HARWOOD MANDRIN INPATIENT CARE CENTER ANNE ARUNDEL If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Days Hours Min **Director** 099-26-9772 Usual Residence of Decedent 1 □ M 2 🛣 F 02/18/1926 YUGOSLAVIA 85 28a-f show er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No MARYLAND FREDERICK FREDERICK Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 2502 SHELLEY CIRCLE 21702 Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify Specify: WHITE 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) DANCE DANCE INSTRUCTOR should be filed with and Mental Hygier 7 is marked other t 12 other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပို EUGENE TALIKOUSKI MICHAEL SWINUHOF 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health as Important: If item 27 is any injury or other. 483 LEITCH ROAD TRACYS LANDING, MARYLAND 20779 MICHAEL ZURALOW/ SON 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ST. VLAD IMIR OF 1 K Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) JACKSON, 01/09/2012 NEW JERSEY LASTING TRIBUTES WNAM CREMATION & AD ANNAPOLIS, MA 21. Signature Funeral Service 22. Name and Address of HELFENBEIN & 814 BESTGATE Name and Address of Facility 23a. Dan 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition 100 Medical resulting in death) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 the as IE FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ ō in the past 12 months? Year Dav Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 尾 Unknown Were autopsy findings available 24a. Was an autops prior to completion of cause of death? performe 2 No 1 ☐ Yes 2 🗷 No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🕭 Other (Specify) MANDRIN funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at HOUSE 28d. Describe how injury occurred Natural 5 Pending injury work? 1 🗌 Yes after death. 2 🗌 No the 1 Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide City or Town, State) within 24 hours a

To the Funeral C

completely filled Medical X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year, 7018 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State

Registrar

Amended #23a per ME, 01/2			Plea	ase Type								_		_	ible.		
per 112, 01/2		For State Registrar	any oo	' Stat	e of N	1arylar	-	artme <i>rtifica</i>				/lental H		0.0	1.0	0.1	005
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Funeral Director		5. Social Security No. 214-74-74.	39	6. Sex 1 ☐ M 2 🕽	7. A	ge (In yrs. i 54	last birthday) Yrs.	If Und Months	er 1 Year Days	If Unde Hours	Min.	8. Date of B	irth 19 /, 24 a <i>r)</i>	1957	9. Birthp Mary	lace (State o	r Foreign
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with the Ma 23a or 28a 1st be notif	Funeral Dire	10e. Street and Nun		Holland S	treet	10f. Zip Code 21502-							10g. C	itizen of W	/hat Coun	1 🗌 Yes	2 MG No
ire, Maryland 21215-0036 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed by Fund	11. Marital Status 1 Never Marri 3 Widowed	•	ried 1 🗌	Decedent d Forces? Yes 2 A , Give or Dates.	Ever in U.s	1	Was Dece If Yes, spe 1 Yes				ecify Yes or No Rican, etc.))-		k, White, e		
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Baltimore, permit. Page 1 and Department of Hee Important: If item any injury or othe		20a. Method of Disp 1 🗖 Burial 2 [4 🗌 Donation	☐ Cremation 5 ☐ Other (S	Specify)	rom State		Place of Disp cometent ore Saint Mic			g)		Date y 12, 2012		ocation - 0		wn, State [aryland	
Bali permit Depar Impor any in		21. Signature of For	1-	icensee			2	2. Name a Durst	nd Addres Funer	s of Facil al Hon	ne, 57 I	Frost Ave	., Fros	stburg, l	MD 2	1532	
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Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending physicic completed filled in by the funeral director, page 2 should be detached for use as the but		IF FEMALE: 23b. Was decedent p in the past 12 m 1 Yes 2 9 Unknown	nonths?	4 🗆 F	ive Birth	of pregnal 2 Feta	Ideath 3	☐ Ectopic ☐ Other (s	pregnanc pecify)	у				23d. Date Mont			ear
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the Ho iin 24 I the Fu	Medical	only one) 3 [☐ Medical E: ☐ Certifying	xaminer: On the Nurse Praction	basis of e	xamination	and/or inves	tigation in	my opinior	n death o	courred at t	the time date	and place	and due to	a the caus	cole) and man	ner stated.
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THAS		30. Name and address	ss of person w	No completed of	ause of d	eath (Item	23a) (Type, F	Print)							_		
State Registra	3	31. Date filed (Month,	Day, Year)	aul Sn	. Registra	ar's Signatu	ure fact	y Me	a Ex	12	4 W	<u> 3rd S</u>	t Cı	ımber	rlan	d MD	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Month Day Kar1 Wilhem 10:10 A M Zimmet January 9 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1806 Jarvis Avenue Prince George's Oxon Hill 5. Social Security Number 9. Birthplace (State or Foreign Country) Holland If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Funeral 8. Date of Birth XX M 2 □ F Days Hours 0270371927 579-50-0615 84Yrs. **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director ms 23a or 28a-f s must be notified 1 Yes 2 X No Maryland Prince George's Oxon Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1806 Jarvis Avenue USA items 2 death v "natural", or item edical Examiner n Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married by Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after If Yes, Give Year or Dates 1 Yes 2 KNo Specify. Completed Specify: White 3X X Widowed 4 ☐ Divorced er than "natur , the Medical F 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Machinist Tool & Die Maker vears event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked or ည Kar1 Wilhem Zimmet Elizabeth Maria Saas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Department of Health Important: If item 27 any injury or other to once. Angelika Zimmet Woodward/Daughter 218 Macov Avenue Culpepper, Virginia 2270 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 XXCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/10/2012 Kalas Crematory Edgewater, Maryland Signature uner le lice Licensee 22. Name and Address of Facility George P. Kalas Funeral Home PA 6160 Oxon Hill Rd. Oxon Hill, Maryland 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ METASTATIC BLADDER CANCER disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exam Cause (Disease or iinjury that initiated events resulting in death) Last the burial-trar Due to (or as a consequence of) nding physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No jo Year 5 Other (specify) Month Day Pregnant at time of death ed by the a detached f 1 ☐ Yes ∠ ☐ 9 ☐ Unknown s been signed by the should be detach Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4XXUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe page 2 After this certificate 2 No Yes 2XX No 1 Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **X X**IO ပ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at work?
1 Yes 28d. Describe how injury occurred injury 1XXNatural 5 Pending 2 | No after death Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined 24 hours a Medical 29a. Certifier 1 🖸 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 — Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 — Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29c. License number 29d. Date signed (Month. Day, Year)

State

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year) Registrar

Joceline Koucetchou

Jocelyn Kouatchou

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Registra s Signa

D63748

4041 Powder Mill Rd. #600 Calverton, Maryland

01/10/2012

20705

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #1 Per, PHY C923 n1/26/2012 and Health and Mental Hygiene

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The state of the s				30. Name and address	ss of person	vho completed			23a) (Tivne P	int) VIAA	56 C	NA	53	48	D		, , ,		
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

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Funeral Director	11. Marital Status		12. Was De	cedent Ever in U	I,S. 13. V	Vas Decedent	f Hispanic Origin? (Suben, Mexican, Puer	pecify Yes or No	- 14. Rac	e - American Inc	lian,					
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où l	21 Signature of Funerat Service Licensee 22 Name and Address of Facility															
8	Lemmon Funeral Home of Dulaney Valley, Inc. Michael J. Flagle Lemmon Funeral Home of Dulaney Valley, Inc.															
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Baltimore, Maryland 21215-0020 RUTH ANDREWS

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1210 PM Sabine **Blake** Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death The Memorial Hospita Eastan Talbot 5. Social Security Numbe If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Hours 127-68-9278 **Director** 1 □ M 2 🛛 F 47 Sept. 13,1964 Germany Usual Residence of Deceden 28a-f show 10c. City, Town or Location with the Maryland items 23a or 28a-f sho her must be notified at 10a. State 10d. Inside City Limits Director 1 Yes 2 V No Maryland Caroline Ridgely 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12518 Ridgely Road Germany 21660 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, event, the Medical Examiner Black, White, etc. þ 1 Never Married 2 X Married Vec 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2 😾 No Specify: Specify: White "natural", Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 years Engineering Clerical Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, and Mental is marked o ၉ Gunter Poh1 other traumatic Markworth Gisela 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 she Department of Health an Important: If item 27 is any injury or other trau Bryant E. Blake (husband) 12518 Ridgely Road Ridgely, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1-28-12 Dulaney Valley Mem. Grdns. Timonium, Maryland 21. Signature of Funeral Service Licensee Mitchell-Wiedefeld Funeral Home, Inc 6500 York Road Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ENCEPHALO PATHY ANOXIC - Ph. sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of, To the Hospital or Attending Physician: The law requires that the death certificate be executed and -tran Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Pregnant at time of death 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 M No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an ate has bage 2 s autopsy death? Yes 2 1 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) B B examiner? 1 ☐ Yes 2 ☑ No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Director: And in by the f Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a Medical 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D0059487 01/22/2012 few potro 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 219 S. Washington St. Easton, Maryland 21601 John Botsis, M.D.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #18 Per FH G923 126/2011 JH State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Jan 1945 Medical 4a. Facility Name (if not institution, give wheet and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Howard County GIUMBID toward If Unde If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan 18, 2012 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Months Maryland **Director** INFANT 1 🛛 M 2 🗆 F Usual Residence of Decede 28a-f show 10b. County unk 10a. State the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No PA Philadelphia 10e. Street and Number 10g. Citizen of What Country? ō 10f. Zip Code "natural", or items 23a o edical Examiner must be with Funeral 19142 2241 Bonaffon St permit. Page 1 and 2 should be filed within 72 hours after death \text{Department of Health and Mental Hygiene.} Important: If item 27 is marked other than "natural", or items amy injury or other traumatic event, the Medical Examiner mu once. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 black 1 ☐ Yes 2 1 No Specify. If Yes, Give Year or Dates Specify Completed 3 - Widowed 4 - Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) INFANT College (1-4 or 5+) INFANT INFANT INFANT Be 17. Father's Name (First, Middle, Last) 18 Moths Name (First, Middle, Maiden Surname) မ Branden Briscoe Alisah Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alisha Jones - mother 2241 Bonaffon St; Philadelphia, PA 19142 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remova 4 ☐ Donation 5 🖾 Other (Specify) 1 cemetery, crematory or other place, Mate 22. Name and Address of Facility State Anatomy Board Director 21201 655 W. Baltimore St; Baltimore, MD art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, bock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ a Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director. Dage 2 should he detached for the funeral director. Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month 012 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Incompetent 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 X No Yes 2 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes ည 1 Nonpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work' 1 Tes 2 🗌 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Expansion On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical Framiner Certifying/Nurse (Check ctifioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title 29d. Date signed (Month, Day, Year) 01-18-2012 ed cause of death (Item 23a) (Type, Print) 30. Name a nd address of person who come

Registrar
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2012

ate filed (Month, Day)

JAN 26

State of Maryland / Department of Health and Mental Hygiene 2012 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Rena E. Brown 4:50 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death Examiner Raltimore usedale 1ave 7. Age (In yrs. last birthday) If Unde 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min. (Month, Day, 218-24-5100 4, Maryland 83 Director 1 □ M 2 🛣 F ept Yrs should be filed within (2.1.2.1) and Mental Hygiene.
7 is marked other than "natural", or items 23a or 28a-1 snown reserved other the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21206 USA 6116 Bel Air Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) unk 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces 7 Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🟋 No Specify: white 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) unk unk waitress food industry injury or other traumatic event, Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ၉ Willie Brown Evella Savage 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 10 N. Calvert St #300; Baltimore, MD 21202 Cassandra Lucas - guardian 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) neral Service License 4 ☐ Donation 5 🛮 Other (Specify) in state 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, teart failure. List only one cause in each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine ocard Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed burial-tran physician Physician/Medical P.O. Box 68760 the use as guipt IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☑ No for Month Day Year Pregnant at time of death ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I þ 1 ☐ Yes 2 M No 3 ☐ Probably 4 ☐ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has page 2 s autopsy performed? Yes 2 No 2 🗆 No certificate 1 Yes Division of Vital After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 \(\subseteq\) Nursing Home \(5 \subseteq\) Residence \(6 \subseteq\) Other (Specify) 2 🗌 No 욘 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred 1 🗹 Natural 5 \square Pending work? 1 Yes 2 No Accident within 24 ours after death.

To the Fu eral Director A completel filled in by the fu Investigation 3 Suicide
4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Configure Nurse Fractitioner: To the best of my however, beath occurred at the time, date and place, and one to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 0455AM Harm Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montzomen Social Security Number Montgomer 9. Birthplace (S If Under 24 Hrs. 8. Date of Birth (Month, Day, Year June 24, 1 If Under **Funeral** 85 Months Days Hours Min. 225-16-1757 1 ▼ M 2 □ F Country)unk **Director** Tune Usual Residence of Decedent 28a-f show 10b. County ms 23a or 28a-f sho must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Washington 1 Yes 2 No DC 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 4235 Dix St NE 20019 USA or items Was Decedent Ever in U.Sunk 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? 14 Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status unk 14 Race - American Indian traumatic event, the Medical Examiner Black, White, etc ò 1 Never Married 2 Married 1 Yes 2 No e filed within ...
antal Hygiene.
...ther than "natural", o 3altimore, Maryland 21215-0036 Specify: black 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation Un (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry un (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) unk unk Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unkshould be file and Mental ! ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18101 Prince Phillip Dr; Olney, MD 20832 Montgomery General Hospital 1 and 2 s f Health a item 27 i injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 21. Signators of Funeral Ser 22. Name and Address of Facility State Anatomy Board 23a. Par 1. Enter the dilease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shirts, or b, art failure. List only one cause on each line.

Immediate the use (Final disease or coordinate coordinate) Director 655 W. Baltimore St; Baltimore, MD 21201 Approximate Onset and Death Physician/ cardiumyopathe disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of). that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death 5 Other (specify) the Unknown 9 Unknown Records, P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires t within 24 hours after death.
To the Funeral Director. After this certificate has been sign completed filled in by the funeral director, page 2 should be completed filled in by the funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? Yes 2 No 2 \square No 1 Yes 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ္ 1 🗌 Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending work? 2 🗀 No Accident Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

HINTH SHARMA-MD

31. Date filed (Month, Day, Year JAN 26

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar 01833 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 21^{pay} 2012 4:00 a.M January Katherine Rose Bryan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Catonsville Commons Baltimore Catonsville 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 219-26-2066 Months Hours **Director** 1 M 2 XF 19,1929 Maryland 82 Dec. Usual Residence of Deceder 28a-f shov ä 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified 1 🗌 Yes 2 💂 No Lansdowne <u>Baltimore</u> MD10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21227 USA 114 4th Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. "natural", or þ 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: 3 Widowed 4 ☐ Divorced Specify: Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Own Home <u>Homemaker</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked o မ Bertha Horein John Spath 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3403 Shannon Drive Baltimore Maryland 21213 1 and 2 s of Health item 27 Penny L. Darciprete-Daughter 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o jo Meadowridge Mem Park |Jan.25,2012|Elkridge Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenset 22. Name and Address of Facility Ambrose Funeral Home Inc. 1328 Sulphur Spring Road Arbutus Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each lipe Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Exami Cause (Disease or injury and that initiated events resulting in death) Last Due to (or as a consequence of): burial attending physician I for use as the buris Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d, Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year signed by the a ld be detached f Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2. No r this certificate haral director, page 2 1 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: a) No Other: 1 🗌 Yes Nursing Home 5 ☐ Residence 6 ☐ Other (Specify ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred eral Director: After filled in by the funer 1- Natural 5 Pending 1 🗌 Yes 2 🗌 No after death ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title

State Registrar

N 2 6 2012 Leneur S. A.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

12

1 Leca

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #26 State BH Maryland 1/36 artiment of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day 18 Brothers Sr. 10:15PM Arthur January 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore 3008 Cedarcrest Avenue Sparrows Point 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) March 20,1916 215-03-0288 Maryland **Director** 1 XM 2 □ F 95 Usual Residence of Decedent 28a-f show 10a. State aţ 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified Maryland Baltimore Sparrows Point 1 🗆 Yes 2 🔀 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or dical Examiner must be Funeral 3008 Cedarcrest Avenue 21219 USA hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3X Widowed 4 □ Divorced Completed Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Painter Local Union 6 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Herschel Brothers Cora Burrier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Brothers daughter 3008 Cedarcrest Avenue, Sparrows Point, MD. 21219 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State January 1 X Burial 2 Cremation 3 Removal from State Timonium, Maryland Dulaney Valley $21, 20\overline{1}2$ 4 Donation 5 Other (Specify) Connelly Funeral Home of Dundalk, PA 7110 Solers Point Road Dundalk, MD 21 21. Signature of Funeral Service License M01176 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, showk, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immeriate Cause (Final Ph sician/ Nove dise se or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease Or Injury that initiated events that the death certificate be executed and burial-tran Due to (or as a consequence of) resulting in death) Last physician Physician/Medical 青44/10に ナン(b Division of Vital Records, P.O. Box 68760 the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) be detached for in the past 12 months? Pregnant at time of death 2 No 9 Unknown Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires Be Completed 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy ☐ Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 21 Medical Certificate: To 1 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpa 4 Nursing Home 5 Residence funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Alatural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Funer completely fi 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 29b. Signature and tale of certifier 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alra

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 201^{Year} Physician/ JANUARY 12:46 PM 19 CLARK GILMORE RAY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S CHEVERLY PRINCE GEORGE'S HOSPITAL 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number . Age (In yrs. last birthday) **Funeral** Months Days Hours (Month, Day, MARCH 2 1944 NORTH CAROLINA Director 1 XM 2 □ F 238-64-0639 67 Usual Residence of Decede ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location Director 1 X Yes 2 No PRINCE GEORGE'S UPPER MARLBORO MD 10e. Street and Numbe 10g. Citizen of What Country? Funeral 4703 MIMSEY ROAD 20772 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 14. Race - American Indian Black, White, etc þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 X No 72 hours after 1 ☐ Yes 2 X No Specify: BLACK Specify. "natural", 3 ☐ Widowed 4 ☐ Divorced Completed Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) 2 should be filed within 72 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) PRIVATE STATION MANAGER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ MARGARET DUBLIN CHARLIE T. CLARK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health are trem 27 i VALENCIA HOLLAND/NIECE 14201 PLEASANT VIEW DRIVE BOWIE, MARYLAND 20720 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 and Department of I Important: If ite any injury or of 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1/28/2012 RIVERDALE CREMATORY RIVERDALE, MARYLAND 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. Signature of Funeral Service Licensee 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or near failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ AnoxIC ience halopath disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events sician and burial-trans resulting in death) Last Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Live Birth 2 Fetal death Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death 1 ∐ Yes 2 ∟ 9 ☐ Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Kenal Clisease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed 1 ☐ Yes 2 ☐ No Yes 2 X No the Hospital or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No မ After this of funeral dir 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🔀Natural 5 Pending n 24 hours after death.

le Funeral Director: Af
oletely filled in by the fu 1 🗌 Yes Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

Division of Vital

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Registrar DHMH 17 Rev 06-2011

within 2 To the I

Medical

29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Jagdeep Singh M.D.

JAN 2 6 2012

MM

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

01/20/2012

29c. License number

3001 Hospital Drive Cheverly, Maryland 20785

D69796

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician CLARK MDA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SILUER SPRING CIROSS HOSPITAL MONTGOMER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ob. 29) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Unk **Funeral** - 82-933 1 □ M 2 1 F Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h. County 10c. City, Town or Location show 7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, The Medical Examinar must be notified at 1 Wes 2 □ No Director SILVER SPRING MONTGOMERY 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20895 3000 MCCOMAS AVE Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No 3 Widowed 4 Divorced WHITE NUN Completed 16a. Decedent's Usual Occupation Unk (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, The Maone. Elementary/Secondary (0-12) College (1-4or 5+) unk 18. Mother's Name (First, Middle, Maiden Surname) 11nk 17. Father's Name (First, Middle, Last) Be ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) HOLY CROSS HOSPITAL RD SILVER 1500 POREST GLEN 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 21. Signatur- of meral Service Li 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death atherosclerotic Cardiovascular miseuses Physician unknown disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examine spital or Attending Physician: The law requires that the death certificate be executed toous after death.

earl Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burlat-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Month Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ Hypertension, DISI pidemia, Diabetes Mellitus 1 Yes 2 No 3 Probably 4 Onknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ပ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day,

Chow dy

CHOWDHURY

30. Name and address of person wheel mpleted cause of death (Item 23a) (Type, Print)

D43121

MD: 605 Main Street, Laurel, MD 20707

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Isaiah A. Cole State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1534 hrs Isaiah Antonio Cole Medical Examiner January 18, 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death St. Agnes Hospital Baltimore 8. Date of Birth(MM/DD/YYYY 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Months Hours Min 02/20/1981 Mary land Director 30 1 XM 2 F 219-96-7902 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No 28a-f show Baltimore MD n/a Baltimore, MD 21215-0036
permt. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Importment of Health and Mental Hygiene.
Importment If item 77 is marked other than "natural", or items 23a or 28a-f sho
injury or other traumatic event, the Medical Examiner must be notified at once. Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 3719 Flowerton Road 21229 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married 1 Yes Specify: Black 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) during most of working life. DO NOT use retired) College (1-4 or 5+) Thurgood Marshall Airport Environmental Technician 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Anthony Andre Midgett Michelle Yolanda Cole 8 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3719 Flowerton Road Baltimore, MD 21229 Michelle Cole/ Mother 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 1 Burial 2 Cremation 3 Removal from State crematory or other place) 1.26.2012 Hanover, MD Ardent Crematory Donation 5 Other Specify of Funeral & 22. Name and Address of Facility
John L. Williams Funeral Directors, P.A 4517 Park Heights Ave Baltimore, MD 21215 Approximate Interval t I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and ure. List only one cause on each line Medical Death a Hypertensive Cardiovascular Disease Examine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. ner Due to (or as a consequence of): if any, leading to immediate cause Enter Underlying Cause Exami (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit Physician/Medical X UNPENDED AMENDED23a,pt.II,27,per me,g925 3-8-12 sm Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If ves. outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Dav 1 Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Diabetes. Hypercholesterolemia, chronic renal failure Completed 24a Was an 24b. Were autopsy findings available mental retardation and seizures autopsy pnor to completion of cause of performed' death? 1 🗸 Yes Yes 2 No 2 No 25. Was case referred to medical 26.Place of Death (Check only one) 8 Other Nursing Home 5 Residence 6 Other: 1 Yes 2 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death Certification: 1 X Natural 1 Yes 2 No Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b Signature and title of certifie January 20, 2012 O.C.M.E 21 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Victor Weedn MD JD 31. Date filed (Month, Day, Year) State JAN 26 Registrar

DHMH 17 Rev 1/2001

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1- For Amend Item 25 per me, g	23',01/24/ Cer	2012dhb tificate of D	eath	F	Reg. No. 2	012 01838		
Physic /Medi		1. Decedent's Name (First, Middle, Last)	Col	leman		2. Date of Dea	ry of	Year 2012 10:45 PM		
Exami		4a. Facility Name (If not institution, give street and number) The Johns Hopkins Hospital		4b. City, Town, or I	City			y of Death		
Funeral Director		217-34-5182	(In yrs. last birthday) 78 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day December	, Year)	9. Birthplace (State or Foreign Country) Baltimore, Maryland		
Maryland f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland	10c. City, Town or Lo	cation imore				10d. Inside City Limits XX Yes 2 □ No		
with the N 3a or 28a-	I Director	10e. Street and Number 1415 Roland Ave.		10f. Zip-Code 21211			_	Citizen of What Country? nited States		
be filed within 72 hours after death with the Maryland that Hyglene. Ad other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Every Armed Forces? 1 □ Yes 2 □ Now If Yes, Give 1. The State of Year or Dates:	0	Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 ☐No	spanic Origin? (Spe n, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White			
thin 72 hours after "hours after "hours after "he matural", or "Medical Examir	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+	(Give	dent's Usual Occupa kind of work done d DO NOT use retired)	luring most of worki	ng	16b. Kind of Own Hon	Business/Industry		
Idlic KIK	Be	12. 17. Father's Name (First, Middle, Last) Alvin Grothe	110	Ullellaker	18. Mother's Name					
Taly 2 shou and N is mai	욘	19a. Informant's Name/Relationship (Type. Print) John C. Coleman, Sr./ Husband	1	ng Address (Street a				n, State, Zip Code)		
		20a. Method of Disposition 1	20b. Place of Dispo) ate / 2012	20c. Location	n - City or Town, State n, Maryland		
Dallino permit. Page Department of Important: If any Injury or		21. Signature of Funeral Service Licensee	land 2121							
Physician /Medical Examiner			consequence of):	ter the mode of dying	morch	or respiratory a	rrest,	Approximate Interval Between Onset and Death		
icate be executed icate be executed physician and its the burial-transit	I Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	consequence of):	1	Labo V	APPROVED BY M	EDICAL EXAMINATION	Interval Between opset and Death		
certif ding use a	n/Medical	dd	of pregnancy			da -	23d. [
the death cery the attendiry the attendirached	Physician/M	in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown		Ectopic pregnancy Other (specify)				Month Day Year		
requires that the de peen signed by the a should be detached	by	Part II. Other significant conditions contributing to death but	it not resulting in the	underlying cause giv	ven in Part I.	23e. Did 1	~/	ontribute to the cause of death? 3 □ Probably 4 □ Unknown		
The law e has bage 2	Completed					24a. Was autor perfo 1 Yes		b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No		
vsician: The lis certificate I director, pa	To Be	M /	nt 2 ER/Outpatier		4 🗆 Nursing no	me 5 🗆 Resi	dence 6 \square 0			
To the Hospital or Attending Physician: 1 within 24 hours after death. To the Funeral Director: After this certificat completely filled in by the funeral director, and the funeral director.	Certification:	27. Manner of Deat Natural 5 Pending (Month, Day) Accident investigation 3 Suicide 6 Could not be determined	Year) Injury ry - At home, farm, sti	M 1		28d. Describe 28f. Location City or Tov	(Street and Nu	mber or Rural Route Number,		
ospital or hours after uneral Dire		29a. Certifier (check only 2 Medical Examiner: On the basis of	f my knowledge, deat examination and/or ir	th occurred at the tin	ne, date and place, pinion, death occu	and due to the	cause(s) and	manner as stated. ce, and due to the cause(s)		
To the Hospital within 24 hours a To the Funeral I completely filled	Medical	one) and manner sta 29b. Signature and title of certifier	ted.	29c. License			29d. Date sig	ned (Month, Day, Year)		
V		30. Name and address of person who completed cause of d	eath (Item 23a) (Type		-	North Mr		7 7 th , Zo12 Baltimore, MD, 21287		
Si Regis	ate	31. Date filed (Month, Day Year) 2012 Server	r's Signature	Kal	000	MOLIII AAG	JIIE OL, E	Jailiniore, 1910, 21207		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death aldwest Physician/ 09 >0 Medical 4a. Facility Name (if hot institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Deati Severno onle /Wersil everno Colle If Under 24 Hrs. Social Security Number 6. Sex If Under 1 Year 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** last birthday (Month, Day, Days Min 1 □ M 2 🔀 F Director 1930 223-32-5937 81 Auq. VA Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10b. County with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Pasadena 1 Yes 2X No Maryland Anne Arundel 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code Funeral 21122 8253 Fenton Lane USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Force Black, White, etc. 1 Never Married 2 Married o, þ ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: "natural", Specify: White 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Mea Elementary/Seconday (0-12) College (1-4 or 5+) 12 Sales Associate Department Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Paul Zarres Mary Nomikous 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8253 Fenton Lane, Pasadena, MD 21122 Sidney R. Caldwell (spouse) Date 23 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place)
Glen Haven Cemetery Jan. Glen Burnie, Maryland 2012 21. Sign of Funera tur rvice L 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heach line. 23a. Part 1. Enter the d ease, or compl Approximate shock, or heart failure. List only one ca Interval Between Onset and Death Immediate Cause (Final Amil Value disease Phylician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence on Hospital or Attending Physician: The law requires that the death certificate be executed and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Records, P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Pregnant at time of death the detached 9 Unknown g | Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform certificate has page 2 25. Was case referred to medical examiner? Division of Vital filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) Hospital 2 No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work?
1 Yes 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 🗌 No 24 hours after death. Funeral Director: A 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 10431 2012 30. Name and address of person who comp ted cause of death (Item 23a) (Type, Print) 32. State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #17 Per FH G924 2/07.2012 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Lewen Dale Childs 2:10 AM 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Heceth land Kehab Anne Arundel Glen Burnie Maryland If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 5. Social Security Numbe 213-30-4432 Age (In yrs. last birthday) 8. Date of Birth Min (Month, Day, Year) Director 1 ▼ M 2 □ F 78 Maryland Feb. 20, 1933 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a. State 10b. Counts 10c. City, Town or Location Director 1 X Yes 2 No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21239 USA 6401 Lochraven Blvd 12. Was Decedent Ever in U.S. Armed Forces?

1 Y Yes 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. "natural", or þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: Specify: Completed 3 Divorced 4 Divorced Year or Dates other traumatic event, the Medical Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) should be filed within 72 I h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) Grocery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ross Childs Marion Monroe Childs Margaret Tugwell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1122 Plover Drive Halethorpe Maryland 21227 19a. Informant's Name/Relationship (Type, Print) Page 1 and 2 sh ment of Health a ant: If item 27 is Ross Childs -Brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jan 24,2012 Woodlawn Maryland Woodlawn Cemetery 22. Name and Address of Facility Ambrose Funeral Home Inc. 21. Signature of Funeral Service Licensee 1328 Sulphur Spring Road Arbutus Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph_sician/ Metastano disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner MOCORCE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami The law requires that the death certificate be executed Cause (Disease or injury Iding physician and Ise as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten for u 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death the signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Division of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed certificate 2 No 1 Yes Yes To the Hospital or Attending Physician: 25. Was case referred to medica funeral director, Be 26. Place of Death (Check only one) examiner? Other: 2X No ည 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28h Time of 28c. Injury at work? 28d. Describe how injury occurred SIGHER CONS 1 Natural 5 Pending 1 🗌 Yes 2 No Investigation 6 Could not be Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) +10 YOR Rd Lectherully 1447 100 Lavla

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death $\overset{3}{4}$. $\overset{\text{Time of Death}}{9}$. $\overset{\text{me of Death}}{\text{me of Death}}$ Month Physician/ Year Dunton, Jr. Robert 2012 Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 5430 Park Heights Avenue N/ABaltimore 8. Date of Birth 7. Age (In yrs. last birthday, 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 217-26-7594 If Under **Funeral Director** 1 ★ M 2 □ F 1931Maryland Mar. 14, 80 28a-f show with the Maryland must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Maryland N/A 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō items 23a Funeral USA 5430 Park Heights Place Apt.111 21215 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

Mi Yes 2 No Korean
If Yes, Give
Year or Dates. the Medical Examiner Black, White, etc ò þ 1 Never Married 2 Married Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No Specify. "natural" 3 Nidowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Private Industry 8th grade Laborer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental F ၉ Mildred Mills Robert Dunton, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau 7159 Fairbrook Road Windsor Mill, MD 21244 Geraldine Burton Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 1cem. Owings Mills, Maryland Garrison Forest Ve 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Chatman-Harris Funeral Home <u>5240 Reisterstow</u>n Road Baltimore,MD 21215 23e. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph iin disease or condition Medical resulting in death) Due to (or as a consequence of) DISEASE **Examiner** dequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) the burial-trai Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 ending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) signed by the atter in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an page 2 s autopsy performe death? 1 Yes 2 No Yes or Attending Physician: the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Tyes 2 X No |은 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d, Describe how injury occurred work? 1 XNatural 5 Pending after death. Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a

To the Funeral C

completely filled Medical 1 Acrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29d. Date signed (Month, Day, Year) 29c. License number 012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHAN State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For Amend Items 24a, 2	te of Marylan	d Depa Cer	923,01926 tificate of D	1 72012 1 Death	and Mental H	ygiene Reg. No. 2 N	12 01842
	Physicia Medic	al	1. Decedent's Name (First, Middle, Last). James, R, Du	erling				2. Date of Month	Death Day 13	Year 22 3. Time of Death
-	Examin	er	4a. Facility Name (if not institution, give street a 4420 Black Rock Rd	•		4b. City, Town, or Hamps		Death	4c. County	of Death rro11
	Funeral Director		5. Social Security Number 6. Sex 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24		Birth (2017) 71,926	9. Birthplace (State or Foreign Country) MD
	Maryland 8a-f show tified at	Director	Usual Residence of Decedent 10a. State 10b. County MD Carrol1		y, Town or Loc	_				10d. Inside City Limits 1 ☐ Yes 2XXNo
	ith the l 3a or 2 t be no	ral Di	10e. Street and Number			10f. Zip Code			10g. Citizen of W	
36	ge 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	d by Funeral	1 Never Married 2 Married 1 F	s Decedent Ever in U.S ned Forces? Yes 2 \sum No es, Give ar or Dates. 1944	li d	Vas Decedent of His Yes, specify Cubar ☐ Yes 2 🗓 No	spanic Origir n, Mexican, F	n? (Specify Yes or N Puerto Rican, etc.)	o- 14. Race Black	USA - American Indian, k, White, etc. White
Maryland 21215-0036	ithin 72 hours iene. r than "natur the Medical E	Completed	15. Decedent's Education (Specify only highest grade com Elementary/Seconday (0-12) 1.0	f working	16b. Kind of Bu					
land 2	ould be filed wit d Mental Hygie marked other matic event, th	a)	17. Father's Name (First, Middle, Last) Martin B. Duerling			s Name (First, Midd	le, Maiden Surname,			
	d 2 should alth and M 27 is mar r traumat		19a. Informant's Name/Relationship (Type, Prin Robert Duerling/So	•					ber, City or Town, St	
altimore,	Page 1 and nent of Heal ant: If item 2 ury or other		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Remov. 4 □ Donation 5 □ Other (Specify)	al from State	emetery, crem	sition (Name of natory or other place	· .	Date 1/16/2012		City or Town, State
Balti	permit. Page 1 and 2 Department of Health Important: If item 2' any injury or other t		21. Signature 1 Funeral Service License	<i>''</i>	22	Name and Addrey	véřacility Teřníty	Funeral H	ome & Cre	matory, P.A. d, MD 21784
23a. F rt 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Ph. sician/ Imr. edi. e Cause (Final disease or condition										
مسيد	Medical Examiner		resulting in death)	COPD.	ience of):		V			
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events	de to for as a consequ						
09	ate be executed physician and the burial-transit	dical	resulting in death) Last	Due to (or as a consequ	ience of):					
. Box 687	ith certific tittending or use as	/Me	in the past 12 months?	es, outcome of pregna Live Birth 2 Feta Pregnant at time of c Unknown	ıl death 3 🗌	Ectopic pregnancy Other (specify)	4		23d. Date Mon	e of delivery hth Day Year
ds, P.O.	requires that the des been signed by the a should be detached f	ed by Ph	Part II. Other significant conditions contributing	ng to death but not res	ulting in the ur	nderlying cause give	en in Part I.		11	bute to the cause of death? 3 Probably 4 Unknown
Division of Vital Records,	The law recate has been page 2 sho	Completed by						pe	topsy pr formed? de	Vere autopsy findings available rior to completion of cause of eath?
Ita	sician: certific irector,	Be	25. Was case referred to medical examiner? 1 Yes No Hospital			Otho	r:	(Check only one)		
on of √	To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate ha completed filled in by the funeral director, page	cate: To		Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury works	4 U Nursi	28d. Describe	sidence 6 Other	
Divisio	al or Atter s after des Il Director ed in by the	Certificate:	3 Suicide 6 Could not be	Place of Injury - At ho building, etc. (Specify)		et, factory, office			(Street and Number own, State)	r or Rural Route Number,
	he Hospit in 24 hour he Funera pleted fille	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To 2 Medical Examiner: On 3 Certifying Nurse Practi	the basis of examination	n and/or investi	gation, in my opinior	n, death occu	irred at the time, date	and place, and due	to the cause(s) and manner stated.
	Not Noth		29b. Signature and title of certifier	I MO.		29c. License	number -002	2517	29d. Date signed	(Month, Day, Year) 3-/2)
			30. Name and address of person who complete Stephen Lai Ken,	d cause of death (Item	23a) (Type, Pi	int) Main	5T.	STE A	Hampste	(Month, Day, Year) 3-12) ad MD 21074
	Stat Registra	-	31. Date filed (Month, Day, Year)	2. Registrar's Signa	ure pau	Kel .				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 6:15 AM Mary H. Davis January Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death Randallstown Season's Hospice/North West Hospital Baltimore 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Dav. Year Director 212-26-9804 1 🗌 M 2 💢 F 84 Yrs. Jan. 2, 1928 Maryland or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Halethorpe 1 Yes 2 X No 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 1816 Summit Ave. 21227 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 11. Marital Status Armed Forces Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black. White, etc. þ 1 X Never Married 2 Married 2 XNo If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: White Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Judicial System other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked of မ Michael Davis (unknown) Julia Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 i Terry Beth Hansen/POA-Friend 1015 Francis Ave., Arbutus, Maryland 21227 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 ☐ Burial 2 ☐XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory Jan. 23,2012 Glen Burnie, Maryland 22. Name and Address of Facility AMBROSE FUNERAL HOME, INC. 21. Signature of Fuderal Service License 1328 Sulphur Spring Rd., Arbutus, Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest e val Between set and Death shock, or heart failure. List only one cause or Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to (or se a consequence of, that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial-Physician/Medical as 1 use a 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? for Month Pregnant at time of death 5 Other (specify) Day Year þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Tes 20 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 4 1 🗌 Yes 2 🗌 No the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tyes 2 X No Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes ieral Director: A filled in by the f Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Funeral I Medical 29a. Certifler 10 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 — Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within . Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Daye signed (Month, Day, Year) 30. Name and address of person who completed cause of death (item 23a) (Typg, Print) smith M) 2535 32. Registra State

Registrar
DHMH 17 Rev 06-2011

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Jak Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) Stephen John 2. Date of Death 3. Time of Death DiBlasi, Sr. Physician/ Month 17/2012 <u>5:15</u>p ^M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Howard 4b. City, Town, or Location of Death **Examiner** Columbia Gilchrist Hospice of Howard County Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Davs 212-44-5537 Director -56-1 **X** M 2 □ F 5/17/45 MD items 23a or 28a-f show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD N/A Baltimore Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 600 Light Street, #919 21230 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ♣ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ ld be filed within 72 hours after of Mental Hygiene. Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify. White Specify. Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Printer Printing Be 17. Father's Name *(First_Middle, Last)* **Samuel J. DiBlasi, Sr.** 18. Mother's Name (First, Middle, Maiden Surname)
Audrey Miles 19a. Informant's Name/Relationship (Type, Print)
Barbara A. DiBlasi / Wife gb. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 600 Light Street, Baltimore MD 21230 Unit#919 20b. Place of Disposition (Name of cemetery, crematory or other place)
Holy Cross Cemetery 1/20/2012 20a. Method of Disposition 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State Baltimore Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Victor P. Doda Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue, Baltimore MD 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death COLON Physician/ disease or condition TWO YEARS Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 should be detached for use as IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months? Month Day Year 4 Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes 2 No To the Hospital or Attending Physician: i within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🗷 No Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🗷 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1🙇 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) 164395 JANUARY 18, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CEBAR LANE COLUMBIA, MD 21044 DANIEUE DOBERMAN, MS 6336 31. Date filed (Month, Day, Year 32. Registrar's Signature JAN 2 6 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** Anna Marie Dimartino 07:24 AM 2012 January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Date of Birth (Month, Day Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Days -820 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County at 1 ☐ Yes 2 ☑ No Funeral Director notified Daltimore 28a-f 10e. Street and Number 10g. Citizen of What Country? , or items 23a or aminer must be n 6 death with 21223 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after Examiner 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ If Yes, Give 3 🗌 Widowed 4 Divorced Year or Dates: "natural" Completed Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) Health and Mental Hygiene. em 27 is marked other than ther traumatic event, the Me College (1-4 or 5+) 10 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Be ည 19b. Mailing Address (Street and Nu er or Rural Route Number, City or permit. Pages 1 and.
Department of Health
Important: If item 27
any injury or other tr
once. 600 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or 1 Burial 2 Cremation 3 Removal from State BAYVICW remateri 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses A1338 PH, 3134 1/1000 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a consequence of Failure **Physician** disease or condition resulting in death) /Medical 12 hours Examiner Troke Sequentially list conditions, it cause. Enter Underlying Cause (Disease or injury that initiated events soulliing indeath). usepks Examine Due to for as a consequence of The law requires that the death certificate be executed burial-transi resulting in death) Last Due to (or as a consequence of) Box 68760, physician Physician/Medical the attending for use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 TEctopic pregnancy Live birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) ed by the at detached f Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ should be 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy page 2 certificate has performed? the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1
☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 🗀 Yes 2 - No Certification: To after death. Director: After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending F 5 Pending investigation (Month, Day Year) 1 Ratural 1 🗌 Yes 2 🗌 No 2 Accident 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 T Homicide Hospital 24 hours 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 January 21, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , MD Monica Cemmon 4940 Eastern Avenue, Baltimore, MD, 21224 31. Date filed (Month, Day, Year) State JAN 2 6 2012

DHMH 17 Rev 1/2001 11595

Registrar

			For State Registrar	State o	f Maryla		artment of rtificate of			lental Hy	giene Reg. No.	2012	01846
	Physicia		1. Decedent's Name (First, Midd Stanley	fle, Last) Ford						2. Date of De Month Jan	Day	2012	3. Time of Death 8:30P M
	/Medic: Examine		4a. Facility Name (If not institution Futureca:	on, give street and nur			4b. City, Town,	or Location				County of De	
	uneral irector		5. Social Security Number 212-58-0381	6. Sex 1 X M 2 □ F	7. Age (In yrs 58	(last birthday) Yrs.	If Under 1 Yea Months Days		Min.	8. Date of Bir (Month, D) 5 / 1 0 /	1 953	9. Bi	rthplace (State or Foreign Sountry) VA
nyland	ahow	hu .	Usual Residence of Decedent 10a. State 10b. Count	у	10c. C	city, Town or Lo		imore					10d. Inside City Limits
th the Ma	or 28a-f ehow e notified at	Director	MD 10e. Street and Number				10f. Zip Code 212				10g. Citiz	zen of What C	
1215-0036 within 72 hours after death with the Maryland	r Iteme 23a Iliner must b	Funerai	2108 Townh		ecify Yes or No Rican, etc.)		nerican Indian, lite, etc. Lack						
メータのアー altimore, Maryland 21215-0036 mit. Pages 1 end 2 should be filed within 72 hours alt noariment of Haalih and Marial Havilana	n "natural", o Medical Exa	pleted by	3 ☐ Widowed 4 ☐ Divorce	nt's Education est grade completed)		16a. Dece	dent's Usual Occi kind of work don DO NOT use retii	upation e during mo		ing		nd of Busines	
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arylan should be	marked imatic ev	To B	Henery	Pribett ship (Type, Print)		19b. Maili	ng Address (Stree	et and Numb		le For		Town, State,	Zip Code) 21234
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altimore,	ortent: If I		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (21. Signature of Fugeral Service	Specify)	State	reenmo	ount_Ce	m 1	1/26	/2012	Mar	cimore cyland Pather	
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8760,	hysicie the bur	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conse	quence of):							
\mathcal{FCRD} $\mathcal{ITANLEY}$ $\mathcal{OI-XI}$ vision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed death.	y the attending pl ched for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		einth 2 □ Fe nant at time of	tal death 3	□Ectopic pregnan □ Other (specify)	су			2	23d. Date of d Month	elivery Day Year
めたごds, P.	eug pe q	ρ	Part II. Other significant condit	ions contributing to de	eath but not re	sulting in the L	underlying cause (given in Part	I.				to the cause of death?
$\mathcal{F}_{\mathcal{O}}$ $\mathcal{A}_{\mathcal{O}}$ $\mathcal{I}_{\mathcal{I}}\mathcal{A}\mathcal{N}\mathcal{L}$ Division of Vital Records, I or Attending Physician: The law requires If	2 5	Completed								24a. Was auto perf 1 🗆 Yes	psy ormęd?	24b. Were prior to death	
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the Hospitel		Medical (29a. Certifier 1 Certify (Check only one)	ing Physician: To the Il Examiner: On the band man	best of my kr asis of examir ner stated.	nowledge, deal nation and/or in	th occurred at the ovestigation, in my	time, date a opinion, de	ind place, ath occur	and due to the red at the time	cause(s) , date and	and manner place, and d	as stated. ue to the cause(s)
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7			30. Name and address of perso				Print)	Balh	mere	MD 21	209		
· .	Stat Registra		31. Date filed (Month, Day, Yea IAN 2 6 201			nature and							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Mansur Froozan State of Maryland / Department of Health and Mental Hygiene 2 () | 2 State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ 0 705 M 5015 mansi Jax 20 Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** moni Sen 86 401 Omery P 8. Date of Birth 9 Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** June 7. Days Country) Months 1 XM 2 □ F Iran 383-76-6442 96 Director Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant. If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Director 1 Yes 2 X No MD Bethesda Montgomery 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number Funeral 4986 Sentinel Drive, Apt. 401 20816 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces?
1 ☐ Yes 2 🗶 No Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes Give Specify: White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Economist Energy Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Unk. Mozafar Froozan Razieh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4986 Sentinel Dr., Apt. 401 Bethesda, MD Gowhar Froozan, wife Baltimore, Important: If item any injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 🔲 Burial 2 💢 Cremation 3 🗆 Removal from State Metro Crematory, Inc. 01/24/12 Baltimore, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee George MacNabb 22. Name and Address of Facility Cremation Society of MD, Inc. Seor 299 Frederick Road 21228 Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) es Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) and use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) nding physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month ģ Day Year Pregnant at time of death signed by the ar 1 Yes 2 L Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔭 Unknown Completed phods 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 😿 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\sum \) Nursing Home 5 \(\mathbb{R}\) Residence 6 \(\sum \) Other (Specify 2 🗌 No ျှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director; After of completed filled in by the funeral work?
1 Yes 2 No injury 1 Natural 2 Accident 5 Pending Self-1-n 9800W Investigation Jan 20 2012 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number City or Town, State) 4 7 . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Home JUr To the Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier one) 29b. Sanature and title of certifie 29d. Date signed (Month, Day, Year) MO DME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year, 32. Registrar's Signature State 26 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 01848 Certificate of Death Reg. No. 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Yeer FRANCE 6-05 AM It leen . January **Physician** 2012 25 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner UISING If Under 1 Year Limore ederic If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Yeer) 6-26-19 Birthplace (State or Foreign Country) 5. Social Security Number Funeral Days -20-3836 Months 1□ M 21 F Yrs. Director Usuel Residence of Decedent Pages 1 and 2 should be filed within 72 hours efter death with the Maryland nent of Health and Mental Hygiene.

Int: If item 27 is marked other than "natural", or Nems 23a or 28a-f show 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r is marked other than "natural", or flems 23a or 28a-f show traumatic event, the Modical Examiner must be nothed at 1 Ves 2 No Funeral Director 4more 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number 1021 USA 21201 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S Armed Forces? 11. Marital Status 2 No 1 ☐ Neyer Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: Blace Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) sera 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle_Last) hana ana 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zin Code) 19a. Jnformant's Name/Relationship (Type, Print) jvidera 51/40. 10 athleei 1homas 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Lecation - City or Town, State 20a. Method of Disposition Date Department of Important: If it any injury or o 1 Burial 2 □ Cremetion 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parrison Forest 22. Name and Address of Fecility 21. Signature of Funeral Service Licensee Mn sure 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical LEUKEMIA The month MYELOID Examiner Due to (or es a consequence of) edical Certification: To Be Completed by Physician/Medical Examiner igned by the ettending physician and be deteched for use es the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) 23b. Did tobecco use contribute to the ceuse of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy PARKINSONISM SENILE DEMENTIA 1 ☐ Yes 2 ☑ No t∐Yes 2₽No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) this After this funeral o 28e. Date of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending 1 W Natural 1 ☐ Yes 2 ☐ No death. eral Director: Af investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after of

To the Funeral Direct

completely filled in by 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the besis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D.30469 30. Neme end address of person who completed cause of death (Item 23e) (Type, Print) NBVELLANKI, 8850, COLUMBIA 100 PARKWAY # 308

DHMH 16 Rev 6/95

State Registrar 32. Registrer's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ $20\overset{\text{Year}}{12}$ 5:15 P M January William Flowers Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Baltimore Towson Gilchrist Hospice Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Days Hours Year) 1959 New Jersey Director 220-66-1098
Usual Residence of Decedent 1 🔀 M 2 🗆 F 52 Yrs 28a-f show 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 XNo MD Baltimore Dunda1k 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21222 USA 2917 Cornwall Rd. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 X Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: "natural", Specify: 3 🗌 Widowed 4 🛄 Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) d Mental Hygiene. marked other than College (1-4 or 5+) Elementary/Secondary (0-12) the 8 0 disabled none Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental 1 ပ Agnes Osinski Joseph Royden Flowers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Cindy Sisson - sister 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or oth 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ※ Other (Specify) in State cemetery, crematory or other place) in state Signature of Funeral Service Ronal d 22. Name and Address of Facility State Anatomy Board tor 655 W. Baltimore St; Baltimore, MD 21201 t 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, och or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami requires that the death certificate be executed burial-trar Due to (or as a consequence of) resulting in death) Last physician Physician/Medical yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Separate at time of death 5 Other (specify) IF FEMALE nse 23b. Was decedent pregnant 23d. Date of delivery for in the past 12 months? Month Year Day Yes 2 ☐ No ed by the a 1 Yes 2 g Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ thknown funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? or Attending Physician: The 2 14 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one, examiner? Hospital 1 Yes Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending s after death. 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Hospital (To the Hospital within 24 hours a To the Funeral C completely filled Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2ga Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of ceptifier 29c. License numbe 29d. Date signed (Month, Day, Year))ブロバ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State

Registrar

ATHI

31. Date filed (Month, Day, Year)

KUMAR

JAN 2 6 2012

Box 68760

P.O.

Records,

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			30. Name and address of person who 31. Date filed (Month, Day, Year) JAN 2 6 201	completed cause of de	eath (Item 2	23a) (Type, I	al BIVE	I. Cum	bula	nd, out	52	502	
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year rarmer 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Himore 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) **Funeral** Min 1 ☐ M 2 💢 F -96-28/1938 Director Usual Residence of Decedent the Maryland la or 28a-f show t be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1XYes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or any Injury or other traumatic event, the Medical Examiner must be n USA 2/20 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Black 3 ☐ Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 10th Pina 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be Freeman 110 2 Brown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Jurray MD 2120 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory 1 Burial 2 ☐ Cremation 3 Removal from State Baltimore, MA 13/2012 Cenit. 4 Donation 5 Dother (Specify) 21. Signature of Funeral Solvice Licensee 22. Name and Address of Facility March FIH - East Marliner. Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final LYMINUOMA ADVHNCED **Physician** 1 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 4☐Pregnant at time of death within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached for 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Conknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 1 ☑ Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation (Month, Day Year) 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) HTITWOING 2012

JU

State Registr<u>ar</u>

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ :20 AM Fields Marie Jan 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner at the Park Esther's Place Battimore If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Sept. 16,1921 West Virginia Days Hours Min. 1 □ M 2🗓 F 217-58-0080 90 Yrs. Director Usual Residence of Decedent show 10d, Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 1 Yes 2 No MD Annapolis Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21409 United States 1055 Lido Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify. Completed 3X Widowed 4 □ Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 9 Years Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Annie Brown Michael Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald R. Fields (Son) 1055 Lido Drive Annapolis, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/25/2012 Baltimore, Maryland Lawn Cemetery 22 Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
Dundalk Marvland 21222 f Funeral Service Licensee 21. Signature Dundalk, Maryland 7922 Wise Ave 23a. Part 1. Enter in disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lier only one cause on each line. Interval Betweer Onset and Death Immediate Cause Final Physiciani dementia lears disease or condition resulting in death) advanced Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? recent 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy performe death? 1 ☐ Yes 2 ☐ No 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work?
1 Yes 2 No X Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and title of certifier

nd address of person who completed cause of death (Item 23a) (Type, Print)

Eastern

ORIGINAL

32. Registrar's Signature

4940

Holder

Date filed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Clifford Llewellyn G		rett	S	ate of Ma		/ Depa		f Health a	nd Me	ental Hy	ygiene	9.2.0.	711	0 0105	
	1- For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2. Date of Death											3. Time of Death			
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		4a. Facility Name (if not institution	on, give street a				4b. City, Town,	or Location	on of Death		4c. County of			
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Funeral Director	ľ	5. Social Security N 579-94-2		6. Sex	1		ast birthday)		_		Foreign Unahimat				
	H	Usual Residence o		1 A M 2	Jr	42	Yr	S			1000 31	1303			
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the Maryland a or 28a-f sh iffied at once		10e. Street and Nu		01 1 7	20			10f. Zip Code		874	l'		SA	uyr	
		13401 Fo	untain	12. Wa	s Deceder		Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American II								
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2 hours		15. Decedent's E.			ege (1-4 o			nt's Usual Occup nost of working I				TOD. KING OF BUS	111622/11	idusiiy	
5-0036 ed within 72 hour fygiene. bygiene. the Medical Exal		121					Ret	ail Sup	ervis	sor		Priv	vate		
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2121 ould be fil d Mental B s marked lic event,		John C. 19a. Informant's Na			t)	_	19b. Mailir	ng Address (St			Jane Bu		ı, State,	Zip Code)20747	
Iltimore, MD 21215-0036 nit. Pages I and 2 should be filed within 72 hours after de arment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or iny or other traumatic event, the Medical Examiner muty or other traumatic event, the Medical Examiner muty or other traumatic and To Be Completed by Fu	1	Alessand				ister						, Forest	vill	e, Maryland	
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Baltimore, permit. Pages I ar Department of Het Important: If ite injury or other tr		21. Signature of Fu		Licensee	201	1110						ins Fune			
Physician	+	23a. Part I Enter ti		r complications	that cause	ed the death								Approximate Interval	
/Medical.	١	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Between Onset and Death Due th													
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Records, P.O. The law requires that ficate has been signed to page 2 should be detailed by		ļ									24a. Was			topsy findings available ompletion of cause of	
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Physician ratios of and direct To B	<u> </u>	examiner?	2 No	Hospital:	ПП		ER/Outpatier		Other				Other		
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Division tall or Attendit as after death. al Director: A led in by the fu	3	2 Accident	Inv	estigation 286	, Place of	Injury - At h	nome, farm, stre	eet, factory, offic			28f. Location (Street and Number	er or Ru	ral Route Number, City	
Division or strending hours after death. Ineral Director: After the filled in by the fune Contribution.	[3 Suicide 4 Homicide		uld not be ermined (Sp	ecify)						or Town, S	State)			
0 - 5 2		29a. Certifier (Check only one)	Certifying I	Physician: To t	he best of	my knowled	dge, death occ	urred at the time	, date and	d place, and	d due to the cau	se(s) and manner and place, and d	as state	ed. e cause(s)	
To the Howithin 24 To the For completel		29b. Signature and		and ma	nner state	d.			ense num			29d. Date signe			
	7	(lax	SP H	All a) K i	_		0.	C.M.E.			January 21	, 2012	2	
	-	30. Name and add													
λ		Carol Allan	•	ssistant Med				Itimore Stre	et, Balt	imore, M	ID 21223				
Stat Registra	te ar	31. Date filed (Mo	1,5 5 X X	112 1	sz. Regisi مر المحاكمة	trar's Signat	Les de	1							
DHMH 17 Rev 1/200					OCM	E	ORIGIN	AL				<u></u>			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 10e, per fh, g923 1-26-12 sm State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar Decedent's Name (First, Middle, Last)
 Joyce Gausepohl 2. Date of Death 3. Time of Death Joyce Month Physician/ 1/9/2012 5:57pm Medical 4a. Facility Name (if not institution, give street and number 4b. City Town, or Location Columbia **Examiner** 4c. County of Death Howard Gilchrist Center Howard County 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 403-48-6847 Hours 72 Director 1 □ M 2**X** F 8/6/39 KY Usual Residence of Decedent or 28a-f show 10c. City, Town or Location 10d. Inside City Limits at Director Anne Arundel MD Severn 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 7193 Coventry Road 23a Completed by Funeral 21144 , or items permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, "natural", or iten edical Examiner r 11. Marital Status Black, White, etc. 1 Never Married 2 XMarried 1 Yes If Yes, Give 2XXNo Baltimore, Maryland 21215-0036 1 Yes XX No Specify: Specify. White 3 Widowed 4 Divorced Year or Dates Health and Mental Hygiene. tem 27 is marked other than "natur other traumatic event, the Medical ! 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Real Estate Real Estate Agent Be 18. Mother's Name (First, Middle, Maiden Sumame)
Lucille Roberts 17. Father's Name (First, Middle, Last) 2 Joseph Hammer 19a. Informant's Name/Relationship (Type, Print) n Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2019 Beach Avenue, Atlantic Beach Florida 32233 Judy Harkleroad /Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State Mother of God Cemetery 1/14/12 1 Burial 2 Cremation 3 Removal from State Fort Wright, injury o 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License Victor P. Doda charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) eeks unamass Medical Due to (or y a consequence of): Examiner Sequentially list conditions. Examine Duret i for es a consequence off if any, leading to immedicause. Enter Underlying Cause (Disease or injury the burial-tra that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 g use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy for Month Pregnant at time of death Other (specify) detached 1 ☐ Yes 27 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Cancer page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performe Yes 2 No 25. Was case referred to medical examiner?

1 ☐ Yes 2 No by the funeral director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: Natural injury 5 Pending after death. Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined filled 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 ho To the Fune completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0060634 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 V 6336 CEDAR I ANE COLUMBIA BINDU

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month ESTER GRIGG lanuary 0 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harbor Hospital Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 004-14-79447. Age (In vrs. last birthday) **Funeral** Months Min 3/19/20 Director 1 **XX**M 2 \square F 91 MΔ or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director MD Baltimore Catonsville 1 Yes 2XXNo 10f. Zip Code 10g. Citizen of What ms 23a or must be n 6348 Frederick Road Funeral 21228 USA Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Examiner Armed Forces?

1 Yes 2 XX Black, White, et-0. 1 Never Married 2 Married by within 72 hours after White Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2XXNo Specify. "natural" Completed 3 X Widowed 4 □ Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working (Specify only highest grade completed) I Hygiene. life. DO NOT use retired Elementary/Secondary (0-12) College (1-4 or 5+) the Ö Electrical Maintenance Boston Edison Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F 2 William Grigg Lauretta A. Drew 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 1237 Harbor Island Walk Baltimore MD 212 19a. Informant's Name/Relationship (Type, Print) Joseph L. Grigg 21230 Son other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 ţ New Riverside Cem Department of Important: If i any injury or o once. 1 Burial 2 Cremation 3 Removal from State New Hampshire 1/17/12 4 ☐ Donation 5 ☐ Other (Specify) proof Funeral Service Licensee Victor P. 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue, Baltimore MD 21230 Signa Doda 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ agruired preumonia ommunit disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy page 2 performed. this certificate 2 No 1 Yes **Division of Vital** 25. Was case referred to medica Hospital or Attending Physician: filled in by the funeral director. 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28b. Time of Date of injury 28c. Injury at To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After 1 Natural 2 Accident (Month, Day, Year) 5 Pending work?
1 ☐ Yes 2 ☐ No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my antique death. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) RESO01 January, 10, 2012 completed cause of death (Item 23a) (Type, Print) 3001 South Hanover Street, Baltimore, Maryland 21225 12 State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jan. 24, 2012 Physician/ 11:54AM Gamble Clevis Mae Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Hospice Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Month, Day, Year 1928 Months Hours N.C 218-26-8898 83 Director May Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f shorms must be notified at Director Md Baltimore 1 ¥ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1650 Woodbourne Ave. Apt.102 21239 USA items 2 filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 11. Marital Status the Medical Examiner Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ō 1 Never Married 2 Married Ś Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates Specify:Black "natural", Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 10th Wire and Assembly Westinghouse other 1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ! ဥ Hardie Lee Stener Heath Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Joquetta Parker (daughter) 214 Cedarmere Circle OwingsMills, Md. 21117 altimore, 20c. Location - City or Town, State Commetery, crematory or other place)

Holly Hills Mem, Garden 20a. Method of Disposition 20b. Place of Disposition (Name of 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Balto.Co,MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Evinaral Service Lacensee Name and Address of Facility Scruggs eston St Calvin B. Scrug 1412 E. Preston Funeral Home 21213 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Onset and Death Immediate Cause (Final Ph_sician/ NGESTIVE disease or condition Medical resulting in death) ue to (or as a consequence of) Examiner Sequentially list conditions Examine days. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) burial-transit Due to (or as a consequence of): nding physician ause as the burial-Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE nse 23b. Was decedent pregnant 23d. Date of delivery in the past 12 mont signed by the atte 5 Other (specify) Month Dav Year Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 CARONARY ARTERY DISOASE Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 has 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certifica completed filled in by the funeral director, I Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICO 1 Tyes 2 No Medical Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific

State Registrar 31. Date filed (Month, Day, Year

DHMH 17 Rev 7/2009

d address of person who completed cause of death (Item 23a) (Type, Print)

76

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 Goodwin Edward George January 16:07 M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Towson Gilchrist Hospice 5. Social Security Number If Under 1 Year | If Under 24 Hrs. g. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 XM 2 - F Months Days Hours June 19 215-16-9770 1923 Maryland Yrs. **Director** 88 Usual Residence of Decedent 10a. State 10b County the Maryland 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f N/A Maryland Baltimore 1X Yes 2 □ No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? must be r Funeral 26 Easton Avenue 21231 USA permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, rmed Forces?

X Yes 2 \sum No Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: White Completed WW II 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Driver Trucking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Joseph Goodwin Ida Marie Braunschweiger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert H. Goodwin Brother 1705 Pisgah Church Road, Greensborough, NC. 27455 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State January cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bavview Crematory 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 24, 2012 Ign yure of Funeral Service License ² Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph_sician/ hi Fracture disease or condition wrekl Medical resulting in death) Due to (or as a consequence of): **Examiner** Fall TINECKS Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) months use as the burial-transit Metashanc Cause (Disease or linjury Cornect that initiated events resulting in death) Last attending physician and for use as the burial-trar V 63.00 Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death signed by the at d be detached for 1 Yes 2 g Unknown Unknown Hospital or Attending Physician: The law requires that the 24 hours after death.
Funeral Director: After this certificate has been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 XA 2 🗌 No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be extuniner? 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPIC-P ည 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 Yes 2 No Certificate: 28b. Time of 28d. Describe how injury occurred 5 Pending injury ☐ Natural Accident Investigation December 27 2011 WK FARL From sounding completed filled in by the 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 26 Street EASTERN BYK. BARMURE M) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Hodical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 only one 29b. Signatu 29c. License number 29d. Date signed (Month, Day, Year) JANUARY 23 2012

DHMH 17 Rev 7/2009

2

State Registrar 31. Date filed (Month, Day,

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N. Churly ST TOUSON MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CAAMUES

Tameka Ros	e Hooker (Ashby)		
12-00567 Unk Unk	Please Type or Print in Black Indelible Ink. En State of Maryland / Department of Health	sure All Copies Are Leginand Mental Hygiene	ible.
	1- For State Certificate of Death	Reg	1. No. 2012 U185
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last) Tameka Rose Hooker (Ashby)	2. Date of Death Month January 20,	
		wn, or Location of Death	4c. County of Death Harford
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under	1 Year If Under 24Hrs. 8. Date of Birth	(MM/DD/YYYY) 9. Birthplace (State or
Director	220-02-3128 1 M 2 F 29 Yrs. Months	Days Hours Min. Nov 29	, 1982 Foreign Country) Maryland
w any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits 1 Yes 2 No
Maryland 28a-f show d at once.	Maryland Harford Aberdeen 10e. Street and Number 10f. Zip C	code 10 ₀	g. Citizen of What Country?
the Maryland sa or 28a-f sh officed at one	16 W. Aztec Street	21001	USA
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Important: If item 37 is marked other than "natural", or items 23a or 28a-f sho injury or other transmatic event, the Medical Examiner must be sotified at once. To Be Completed by Funeral Director	1 Never Married 2 X Married Armed Forces? If Yes, specify	t of Hispanic Origin? (Specify Yes or No- Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
s after de riner number number mu	1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year or Dates:	No specify:	Specify: White
"natur Exami	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	ccupation (Give kind of work done ing life. DO NOT use retired)	16b. Kind of Business/Industry
5-0036 ed within 72 hour tygiene. other than "natu the Medical Exan Completed	12 Maid		Hotel
215-0 be filed v ntal Hygin rked other cent, the I	17. Father's Name (First, Middle, Last) Albert E. Biggs	18.Mother's Name (First, Middle, Ma Kathleen Virgi	
212 hould by hould by is mark itic ever	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address	(Street and Number or Rural Route Numb	per, City or Town, State, Zip Code)
y, MC and 2 si feath ar tem 27 traum	20a. Method of Disposition 20b. Place of Disposition (Name	c Street Aberdeen, of cemetery, Date	Maryland 21001 20c. Location - City or Town, State
more Pages 1 ent of H ut: Uri	1 Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: Metro Crematory	y Inc. 01/25/12	Baltimore, Maryland
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: Witem 27 is marked other than injury or other transmatic event, the Medica	21. Signature of Funeral Service Licensee Thomas Gregor 22. Name and A Crematic 299 Free 23a. Part I. Enter the disease, a complication (that caused the death. Do not enter the mode of	ddress of Facility Of Maryl	and, Inc.
Physician	23a. Part I. Enter the disease, a complication (t) at caused the death. Do not enter the mode of	dying, such as cardiac or respiratory arres	te Maryland 21228 st, shock, or heart Approximate Interval Between Onset and
/Medical examiner	failure. List only one cause on each line. Immediate Cause (Final disease a. Carbon Monoxide Intoxication		Death
	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.		
aminer	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated		
	events resulting in death) Last Due to (or as a consequence of): d.		
re executed cian and irial - transi	UNPENDED AMENDED		
68760, certificate be anding physicine as the burine as the burine cian/Med	IF FEMALE: 23b. Was decedent pregnant in the 2 Fetal death	3 Ectopic pregnancy	23d. Date of delivery Month Day Year
of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and tuneral director, page 2 should be detached for use as the burial - transit on: To Be Completed by Physician/Medical Exp.?	past 12 months? 4 Pregnant at time of death 5 Other (Specif	(y)	
Records, P.O. Box The law requires that the death cate has been signed by the atte page 2 should be detached for u Completed by Physis	Part II. Other significant conditions contributing to death but not resulting in the underlying of	addo giroir iir i ar ii	pacco use contribute to the cause of death?
s, P.(uires that a signed an signed a by		1 Yes	2 No 3 Probably 4 Unknown 1 24b. Were autopsy findings available
Records, The law requires freate has been signage 2 should be		autops perform	y prior to completion of cause of ned? death?
II Rentificate ruificate ror. page		1 Yes 2 5.Place of Death (Check only one)	No 1 Yes 2 No
F Vital Physician: r this certial director	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 DO		Residence 6 Other:
	1 Natural 5 Pending FOUND: FOUND:	Subject expo	sed to carbon monoxide from heater in an enclosed space
Division of Vital Records, P.O. Hospital or Attending Physician: The law requires that the 24 hours after death. Runeral Director: After this certificate has been signed by rely filled in by the funeral director, page 2 should be detach all Certification: To Be Completed by P.	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, or	office building, etc. 28f. Location (St	rreet and Number or Rural Route Number, City ate) ost Road , Aberdeen , MD
C Life of the Co.	4 Homicide determined (Specify) In Tent in Woods 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time.		
Division To the Bospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my of and manner stated.	opinion, death occurred at the time, date a	nd place, and due to the cause(s)
6 6		O.C.M.E.	29d. Date signed (Month, Day, Year) January 21, 2012
OGME	30. Name and address person who completed cause of death (Item 23a)		
. 15		imore Street, Baltimore, MD 212	223
State Registrar	31. Date filed (Month Day Year) 32. Registrary Signature		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Harr onnie Medical City, Town, or Location of Death 4c County of Deg (if not institution, give street and number) **Examiner** Anne Hr lak Manor Drive 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral Director** 28a-f shov 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 1 Yes 2 146 10f. Zip Code 10g. Citizen of What Country? 21061 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces?
1 1 Yes 2 No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working Elementary/Secondary (0-12) College (1-4 or 5+) 21 rs Be 17. Father's Name (First, Middle, Last) 2 19b. Mailing Address (Street and Number or Rural Route Num 1631 Langtord Road, Bab 19a. Informant's Name/Relationship (Type, Print) nber, City or Town, State, Zip Code) Veronica 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 28-12 4 Donation 5 Other (Specify) e of Funcial Service Lice see 23a. Part 1. Enterne disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 2 m in the Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, cause (Disease or injury that initiated events Due to for as a nonsequence off and resulting in death) Last Due to (or as a consequence of). the attending physician a hed for use as the burial-Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Yes 1 ☐ Yes ∠ ∟ 9 ☐ Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 ☐ Yes 2 KNo 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy this certificate has perform 2 No ☐ Yes 2 🕢 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 ONO Hospital Other: 1 Yes ၉ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred iniury 1 Natural 5 Pending 2 Accident Investigation Suicide 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 14 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 38762 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

JAN 2 6 2012 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 0823 Timothy Brian Hetherington AM January 2013 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Hagerstown Meritus Medical Center 5. Social Security Number Unk | 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) UNK **Funeral** Hours 54 1 X M 2 □ F **Director** Usual Residence of Decedent 23, 28a-f show 10a. State 10b. County than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 No Washington Hagerstown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21742 16 Bel View Ave. Funeral with 72 hours after death 12. Was Decedent Ever in U.S. unk 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status \mathbf{unk} 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 white 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation unk 16b. Kind of Business/Industry (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) unk Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) ည traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Valadia Kristerfferson – friend 16 Bel View Ave; Hagerstown, MD 21742 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 🗓 Other (Specify) in state 21. Signature Funeral Service Licer 22. Name and Address of Facility State Anatomy Board *x*ector 655 W. Baltimore St; Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph_sician/ METASTATIC disease or condition Medical resulting in death) Due to (or as a consequence of Examine MALIGNANT EFFUSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Cause (Disease or injury that initiated events resulting in death) Last PAGUMONIA OBS New of NE and Due to (or as a consequence of) nding physiciar Hypotem, A Physician/Medical P.O. Box 68760 for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) atter in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signer should be c Completed by FIBLILLATOR Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4. ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has director, page 2 autopsy performe this certificate 2 🗌 No 1 Yes Division of Vital 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital 2 X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of injury (Month, Day, Year) . Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A Accident Investigation completely filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the F Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year,

Registrar

1116

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ALY AL

JAN 2 6 2012

31. Date filed (Month, Day, Year)

WINEMU

00062006

MEDICAL CAMPUS DD

MY GUTOWN MA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

largaret C. Handel	1- For State	epartment of Health and Certificate of Death		2012 0186 Reg. No.
Physician/ Medical Examiner	Registrar 1. Decedent's Name (First, Middle,Last) MARGARET C. HANDEL		2. Date of De Month January 2	22, 2012 3. Time of Death 1310 hrs
)	4a. Facility Name (if not institution, give street and number) Good Samaritan Hospital	4b. City, Town, o Baltimore	or Location of Death	4c. County of Death Baltimore City
Funeral Director	5. Social Security Number 6. Sex 7. Age (In 213-30-9457 1 M 2 F 79	yrs. last birthday) If Under 1 Ye Months Da	House Min	irth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) MD.
Maryland 28a-f show any d at once. ector	1 5 3 1	City, Town or Location	e County	10d. Inside City Limits 1 Yes 2 No
with the Maryland ms 23a or 28a-f sho be notified at once eral Director	10e. Street and Number 8413 Kingsridge Rd.	10f. Zip Code	21234	10g. Citizen of What Country? USA
fter death ", or itel or must	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 X 3 X Widowed 4 Divorced If Yes, Give Year	If Yes, specify Cub.	lispanic Origin? (Specify Yes or N an, Mexican, Puerto Rican, etc.) o specify:	o- 14. Race - American Indian, Black, White, etc. Specify: White
5-0036 led within 72 hours aft. Hygiene. other than "natural" the Medical Examine Completed by	15. Decedent's Education (Specify only highest grade complet Elementary/Secondary (0-12) College (1-4 or 5+) 12 yrs N/A	16a. Decedent's Usual Occup during most of working li		16b. Kind of Business/Industry Housekeeping-Own Home
D 21215-0036 should be filed within 72 and Mental Hygiene. The marked other than Instite event, the Medical To Be Comple	William A.York		18.Mother's Name (First, Middle, Margaret Sch.	Maiden Surname)
re, MD 21 I and 2 should Health and Me fitem 27 is ma re traumatic ev	Donald Handel (Son)	7720 Chapma	n Rd. Kingsville	
	4 VV Duriel 3 Comption 3 Permanal from State	20b. Place of Disposition (Name of o crematory or other place) Immanuel Luth.Ch.	Cem. 1-27-12	20c. Location - City or Town, State Baltimore, Md.
Baltimo permit. Pages Department of Important:	21. Signature of Funeral Service Licensee	22. Name and Addre	r Rd. Baltimore	uneral Home , Md. 2;236
Physician Medi Examiner	23a Part I. Eater the disease, or complications that caused the failure. List only one cause on each line. Fluoxeti Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence)	ine and lmipramin Atherosclerotic	e intoxication c	omplicating Between Onset and
red Insit Examiner	Sequentially list randitions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseque			
execution and an and an and an and and an and and	d. X UNPENDED AMENDED 23a, 2	7,28a-f,per me,g	25 3-23-12 sm	
cer ficate be mid ng physici use as the buri	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of 1 Live birth 4 Pregnant at time 9 Unknown	2 Fetal death	Ectopic pregnancy	23d. Date of delivery Month Day Year
, P.O. Box res that the death signed by the att be detached for d by Physi		it not resulting in the underlying cause	g	tobacco use contribute to the cause of death? es 2 No 3 Probably 4 V Unknown
cords law requi			1 V Yes	s an ppsy formed? 24b. Were autopsy findings available prior to completion of cause of death? 1 Ves 2 No
F Vital Rec Physician: The Ir this certificate al director, page To Be Con	25. Was case referred to medical examiner?	26.Pla 2 ✓ ER/Outpatient 3 DOA	Other Nursing Home 5	Residence 6 Other:
Division of N ppital or Attending Phy nours after death. neral Director: After th filled in by the funeral Certification: T			Yes 2 X No subjec	e how injury occurred t did not clear ibed medications (Street and Number or Rural Route Number, City State 8413 King Ridge Rd.
Division Hospital or Atten 24 hours after death Funeral Director: tely filled in by the		und:Residence	Baltim	ore,MD.
To the Hos within 24 h To the Fun completely	(Check only one) 2 Medical Examiner: On the basis of examine and manner stated.	ation and/or investigation, in my opini	on, death occurred at the time, dat	te and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)
	29b. Signature and title of certifier		C.M.E.	January 23, 2012
	30. Name and address of person who completed cause of death Ana Rubio MD. Assistant Medical Examine	h (Item 23a) er 900 W. Baltimore Stree	t, Baltimore, MD 21223	
State Registra		Signature Sand		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 January 21 Joyce Lee Harris 1:20 aΜ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Stella Maris Hospice Timonium If Under 24 Hrs. Hours Min. Social Security Number . Age (In vrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Year) 06/11/1945 218-44-9744 Director 1 🗆 M 2 🗐 🗶 MD 66 Yrs. Usual Residence of Decedent 23a or 28a-f show 10b. County 10c. City, Town or Location event, the Medical Examiner must be notified at 10d. Inside City Limits Director Baltimore Parkton MD 1 ☐ Yes 2 ₹ No 0e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 20419 Downes Road 21120 USA Was Deceas.
Armed Forces?

Ves 2 No 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🕅 No Specify: White Specify. 3 ₩Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Domestic Engineering Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Boyd Martin Florence Krowe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Don & Kelly Harris-Children 20419 Downes Rd Parkton, MD 21120 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State Ardent Crematory 1.24.2012 Hanover, M D 5 Other (Specify) John L. Williams Funeral Directors, P.A. 4517 Park Heights Ave Baltimore, M C 21215 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest k, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition LUNG CANCER Medical resulting in death) Due to (or as a consequence of). Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnar 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 X No Month Dav Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Hospital or Attending Physician: The law requires Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 Yes 2 X No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 🗶 No Other: ျ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: X Natural 5 Pending Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗶 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and t person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

IAN 2 6 2012

1:20

JOKCE

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

12-00572 Dominic Hope

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ominic Hope		1- For State Registrar	State of Maryland		rtment of <i>tificate of</i>		nd Menta	Re	eg. No. 201	2 0186
Physici Medical Exami		Decedent's Name (First, Mic Dominic Willia						2. Date of Deat Month January 20	Day Year	3. Time of Death 1926 hrs
		4a. Facility Name (if not institut University Hospital	ion, give street and numbe	r)	4	b: City, Town, o	or Location of D		4c. County of Death	1
Funeral Director		5. Social Security Number 217–94~0665	6. Sex 7. A	ge (In yrs. la	st birthday) Yrs.	If Under 1 Ye Months Da	ear If Under 2 ays Hours	8. Date of Bin Min. 127127	/19/9 1Foreig	thplace (State or gn untry) MD
any		Usual Residence of Decedent 10a. State 10b. Count	y	10c. City,	Town or Location	on				10d. Inside City Limits
≜	ō	MD n	/a		Balt	imore				1 X Yes 2 No
he Maryl 1 or 28n-i	Director	10e. Street and Number 2852 Bookert 1	Drive			10f. Zip Code	1225	10	og. Citizen of What Cou USA	ntry?
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland eatht and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28s-f sho fraumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 X Never Married 2	Married 12. Was Deceder Armed Forces 1 Yes		If Ye	es, specify Cub	an, Mexican, P	? (Specify Yes or No- uerto Rican, etc.)	White, etc.	ican Indian, Black,
irs after ural", iminer	ò	3 Widowed 4 D 15. Decedent's Education (Sp	ivorced or Dates: ecify only highest grade co	ompleted)	16a. Decedent		ation (Give kin		Specify: Bla 16b. Kind of Business/	
11 21 5-0036 Id be filed within 72 hours after forntal Hygiene. narked other than "natural", event, the Medical Examiner.	Completed	Elementary/Secondary (0-12			J	ost of working li	fe. DO NOT us	e retired)	Baltimore	City Gov't
21215-0036 wild be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be Co	17. Father's Name (First, Middle william Hope	e, Last)					Name (First, Middle, N lotte Ann		
2121 should be fill and Mental F is marked atic event,	일	19a. Informant's Name/Relation							nber, City or Town, State	e, Zip Code)
e, MD and 2 shc Health and item 27 is traumati		Charlotte Mar 20a. Method of Disposition			lace of Disposi	tion (Name of c		Baltimore,	20c. Location - City or	Town, State
Baltimore, MD 2 sernit. Pages I and 2 shoul Department of Health and N important: If item 27 is n injury or other traumatic		1 X Burial 2 Cremation 4 Donation 5 Other		icato	rematory or oth g Memor		ck	1.28.2012	Randallsto	own, MD
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and M Important: If item 27 is minjury or other traumatic.		21. Signature of Funeral Service	Lio see		22. N Joh 1451	ame and Addre IN L. Will 7 Park	illiams Height	Funeral D	Directors, I	2.A. 21215
Physician	3 E	23a. Part I. Enter the disease, falure. List only one caus	se on each line.		Do not enter th	e mode of dyin	g, such as card	diac or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final diseas or condition resulting in death)								Boder
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Caus	b	sequence of):					
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iO, e be executed ysician and burial - transit	edical	UNPENDED	d. X AMENDED	orFU /	G924/2/	1/2012	W.C.			
Box 68760, ne death certific" e by the attending physic are for use as the but	- S I	IF FEMALE: 23b. Was decedent pregnant in past 12 months?	the 23c. If yes, outcome the 1 Live birth		ancy 2 Fet		Ectopic p	regnancy	23d. Date of deliver Month	y Day Year
. Boy he death y the att	hysi	1 Yes 2 No 9 U	nknown g Unknown	ath but not re			a given in Part I	23e Did to	bacco use contribute to	the cause of death?
ires that the signed by	ρ	- I at the Other Significant conte	state to document to document	an bachot ro	Salaring III tillo di	-	- given with dire		2 ✓ No 3 Pro	
cords law requ has been 2 shoule	Completed							24a. Was a autop: perfor 1 🗸 Yes	sy prior to med? death?	utopsy findings available completion of cause of
Vital Rec yyician: The his certificate director, page	å	25. Was case referred to medic examiner?	O to a situate	ient 2	ER/Outpatient		ce of Death (Ci	heck only one)	Residence 6 Othe	r.
on of Virthering Physical III.	tion: To		28a. Date of In (Month, Day Jan 20, 201	jury	28b. Time of In	njury 28c. In	jury at Work? Yes 2 ✔ N	28d. Describe t	now injury occurred	
_> ₽ % ¥ ≅	Certification:	3 Suicide 6 Co	vestigation uld not be termined (Specify) B:		me, farm, stree	t, factory, office	e building, etc.		Street and Number or Ru tate) more Street, Baltimo	ural Route Number, City
Divi	Medical Ce	4 Homicide 29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician To the best of caminer On the basis of ex	my knowledg amination ar	e. death occurr	red at the time, on, in my opini	date and place on, death occur	a, and due to the caus	e(s) and manner as stat	ted.
To with	Me	29b. Signature and title of certi	fier and manner stated	1.			nse number		29d. Date signed (Mo	
HV.		30. Name and address of person								
OCME	nte	Mary G. Ripple MD. 31. Date filed (Month, Day, Yea.	Deputy Chief Med			W. Baltimo	re Street, B	Baltimore, MD 21	223	
Si Regis	trar	1AN 2 6 20	112 /2 mar	1.	parke					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month N 1AR) HALE 10:45PM 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Ellicott City Health & Rehab. Ellciott City Howard If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 214-44-5432 Director 1 M 2 X F 03 66 16 45 MD show 10c. City, Town or Location 10d. Inside City Limits Director must be notified 28a-f Catonsville 1 Yes 2 X No Baltimore 10f. Zip Code 5 10e. Street and Number 10g. Citizen of What Country? Funeral 23a 19 Winters Lane 21228 U.S.A. ral", or items 2 Examiner mus 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian, "natural", or þ 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: Black Completed 3 ₩ Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) should be filed within 72 I h and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4 or 5+) Suntrust Bank 12th grade <u>Accounting Processer</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Harriett Levinia Eldridge Merrill Buddy Dorsey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1701 Commons Ct., Baltimore, Md 21237 Norman Bennett-Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2/1/2012 Owings Mills, Md Garrison Forest ature of Funeral Service Licensee 22. Name and Address of Facility March F/H West & Mugnet 4300 Wabash Ave, Baltimore, Md 3a. Par 1. Enter the disease, or complications to treat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Onset and Death ARREST Physician/ Medical resulting in death) Due to (or as a consequence of Examiner DISEAGE EMD STAG Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examin HYPERTENLION attending physician and I for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 🗀 Fetal deat Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the at Id be detached for 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 2 ☐ Ne 3 ☐ Probably 4 ☐ Unknown should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy performed' death? To the Funeral Director: After this certificate Yes 2 🗌 No 2 🔽 Yes Division of Vital completely filled in by the funeral director, 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 ☐ NO 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending 1 Watural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) PHYSICIAN D 0062704 JAN 24 2012 address of person who completed cause of death (Item 23a) (Type, Print) N. Ridge Rd. , Svite 100 MD 3296 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 0 1 Month $2\,2^{\text{Day}}$ Physician/ 2012 Marcella Hurd Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** A\N Baltimore 2927 Violet Ave. If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 213-24-7736 1 □ M 2 F Director 82 10/12/1929 Maryland Usual Residence of Decedent 3a or 28a-f show t be notified at 10b. County 10a. State 10c. City, Town or Location MD N/A Baltimore 23a or 2 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral the Medical Examiner must U.S.A. 2927 Violet Ave. 21215 "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. ò 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Specify: Black 3 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 10th Grade N/AHousewife Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fisher is marked o မ Anna Brown Wilson Lowery 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health s 3905 Eldorado Ave., Baltimore, MD 21215 Marie Davis(daughter) Baltimore, If item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If ite any injury or ott Burial 2 Cremation 3 Removal from State 01/31/12 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Signature of Funeral Service Licensee a. Left 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ CONGESTIVE HEART disease or condition resulting in death) Medical Examiner ARTERY ORONARY Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last as the buria physician Physician/Medical 68760 use a yes, outcome of pregnancy Live Birth 2 Fetal death 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) 23b, Was decedent pregnant Box in the past 12 months? 1 Yes 2 No 9 Unknown for 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I ģ HYPERTENSION Records, Completed MELLIMS DIABETES 24a. Was an autopsy performed? Yes 2 of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 200 Other: 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at s after dea... ral Director: After 5 \square Pending Division Accident Suicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by ☐ Homicide within 24 hours a To the Funeral C completely filled Hospital Medical 29a, Certifier 3 Certifying Nurse P

Owings Mills, MD 2josephorn obrown Jr Funeral Home Mare 2140 N. Fulton Ave., Baltimore, MD21217 Approximate Interval Between Onset and Death 23d. Date of delivery Month Day 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 🗌 No 1 Yes 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical examine on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated actitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. D53534 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1501 SOUTH CLINTON STREET BACTIMORE CONNORS ORIGINAL

3. Time of Death

10d. Inside City Limits 1 🙀 Yes 2 🗆 No

11:50pm

State Registrar 29b. Signature and title of certifier

KOBERT

31. Date filed (Monti

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 2 For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Donald Merle Ireland January 2012 4:30 Ам Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Baltimore 6220 Plymouth Road 5. Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days 219-22-6543 Director 1 **X** M 2 □ F Maryland 84 08-09-1927 Usual Residence of Deced 28a-f show 10a. State 10b. Count 10c. City. Town or Location 10d. Inside City Limits Director must be notified N/A Baltimore Maryland 1 X Yes 2 No ō 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral USA 6220 Plymouth Road 21214 items death 12. Was Decedent Ever in U.S. Armed Forces?
1 X Yes 2 □ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify. Completed 3 Widowed 4 Divorced White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Maintenance Mechanic Concrete Industry other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 James N. Ireland Veta L. Hall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Ste 6220 Plymouth Road Baltimore, Maryland 21214 19a. Informant's Name/Relationship (Type, Print) Department of Health an Important: If item 27 is 1 any injury or other 6220 Plymouth Road Mrs. Lee Etta Ireland - Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Cedar Hill Cemetery 01-25-2012 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road ign vire of Puneral Service Licenses Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or injury that initiated events that the death certificate be executed the burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 ding p IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) ō in the past 12 months? Day Month Year Pregnant at time of death Yes 2 No been signed by the a should be detached g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an or Attending Physician: The law page 2 has autopsy performed 1 Yes 2 No 1 Yes 2 4 To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 20 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 27. Manner of 28a. Date of injury (Month, Day, Year) Certificate: 28h Time of 28c. Injury at 28d. Describe how injury occurred Mural 5 Pending work 1 Tyes 2 🗌 No the Accident Investigation Could not be Director: 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determine To the Hospital within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) cause of death (Item 23a) (Type, Print) 01 onl 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dorothy Jackson 201 5:35 AM January Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Regional Hospita Laure Prince (reorge's 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 9. Birthplace (State or Foreign Months Days 1 □ M 2 🕱 F Min 219-22-0085 83 Yrs. Director June 1928 Baltimore. Usual Residence of Decedent show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f Laurel 1X Yes 2 ☐ No MD Prince George's 10e. Street and Number ö 10f. Zip Code 10a. Citizen of What Country? the Medical Examiner must be Funeral 23a 7334 Summerwind Circle 20707 USA items, filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 9 Ď 1 Never Married 2 X Married Yes 2X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 'natural", 3 🗆 Widowed 4 🗆 Divorced Completed Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Government Clerk 12th and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Department of Health and Ment. Important: If item 27 is marked any injury or out. James Robert Thomas Mattie Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Caleb J. Jackson/ Son 13704 Eyton Court, Upper Marlboro, Maryland 20774 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery | 01/31/2012 | Brentwood, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility $\, {f J}_{ullet} \, {f B}_{ullet} \,$ Jenkins Funeral Home Naphnelf . Cornel 7474 Landover Road, Landover, Maryland 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Dilated ardiomyo disease or condition Medical resulting in death) **Examiner** Eague Heny list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Exami The law requires that the death certificate be executed and Due to (or as a consequence of) -burial-Physician/Medical P.O. Box 68760 phys the L as ding IF FEMALE: asn 23c. If yes, outcome of pregnancy 1 Live Birth 2 Tetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ o in the past 12 months?
1 Yes 2 No Year Month Day Pregnant at time of death Unknown g Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 No certificate 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) 1 Yes 2 XNo Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA this 4 Nursing Home 5 Residence 6 Other (Specify, funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: After 1 28c. Injury at 28d. Describe how injury occurred 1 X Natural work? 1 Pyes 2 No 5 Pending injury 4 hours after death.

uneral Director: Aft
ed filled in by the fur Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Medical Example 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier npleted f within 2 To the F complet 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2012 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7300 Van Dusen Road Gorantla Laurel Regional Hospita 20707

DHMH 17 Rev 7/2009

State Registr<u>ar</u>

12-00578	
Peggy Jackson	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2012 01868

	1- For State Registrar		,	Certifica	ite of Dea	th		Reg	No.	
Physician/ Medical Examine	1. Decedent's Nan	ne (First, Middle,Last	ackso	2.0				Date of Death Month [Day Year	3. Time of Death 0456 hrs
meulcai Examine	1 7 9	(if not institution, give		26)	4b. City.	Town, or Location		anuary 21,	2012 4c. County of Dea	
		kins Bayview Me				more				
Funeral Director	5. Social Security 220 • 62 •	0614 1	7. Ag	e (In yrs. last birth	Yrs. If Und Mont			. Date of Birth	MM/DD/YYYY) 9. E Fore	
any	Usual Residence of 10a. State	10b, County	-	10c. City, Town of	or Location					10d. Inside City Limits
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the Maryland as or 28a-f si otified at one		Amber	wood 7	Rd Apt	4-C	2120	6	10g	Citizen of What Co	ountry?
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2121 tould be fill d Mental Is is marked tic event,	19a. Informant's N	ame/Relationsy	pe, Prit)	ON) 19b	. Mailing Addres	s (Street and Nur			er, City or Town, Sta	te, Zip Code)
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ore, MC es 1 and 2 si of Health at If item 27 ther traums	20a. Method of Dis	sposition Cremation 3	Removal from Sta	ate cremato	Disposition (Na ry or other place) –	Da	ate 2	20c. Location - City (or Town, State
트 및 일 등 등	4 Donation 5	Other Specify:	-	Green	sourt (i	enatory	1/31	2012	Bajtim	ore, MD
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Vital Records ysician: The law requir his certificate has been director, page 2 should o Be Complete	25. Was case refer	rred to medical				26.Place of Death	(Check only	1 Yes 2 one)	No 1 🗸	Yes 2 No
f Vital Physician: Fritis certi ral director	examiner? 1 Yes	2 No	ospital: 1 Inpatie	nt 2 🗹 ER/Ou	tpatient 3 [DOA Other	Nursing Ho	ome 5 Re	esidence 6 Oth	er:
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isior Attend Attend rector: by the	2 Accident	Investigation	28e Place of Ini	iury - At home, far	m. street, factor	y, office building, e		Location (Stre	eet and Number or F	Rural Route Number, City
Division o spital or Attending to a strength ours after death. In the strength of the strengt	3 Suicide 4 Homicide	6 Could not b determined	e (Specify)	,,	,,	,,		or Town, Stat		1
Division of Vital Records, P.O. Box 687. To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as the fine of the funeral Certification: To Be Completed by Physicians Medical Certification: To Be Completed by Physicians	29a. Certifier 1 (Check only one) 2	Certifying Physicia Medical Examiner:	-							
A SH S	29b. Signature and				29	c. License number			9d. Date signed (M	
	3)	<u> </u>				O.C.M.E.			January 22, 20 [.]	12
		ress of person who co /incenti, MD /	ompleted cause of do Assistant Medic		900 W. Ba	ltimore Street,	, Baltimore	e, MD 2122	23	
	31. Date filed (Mon		32. Registrar							
Registrar	LJAN	2 6 2012	(buens	A. 130	plar _					

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State of Maryland / Department of Health and Mental Hygiene 2012 01869

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s 23a		115 Ashland Place	Lagrana		140	1120			**- V **	US	Race - Amer	con Indian	
ire, Maryland 21215-0036 s.1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 2 1 1 1 2 1 2 1 1 2 1 2 1 2 1 2 1 2			Was Decedent of H If Yes, specify Cuba 1 ☐ Yes			Rican, etc.)		Black, White		
21215-0036 d within 72 hours af glene. er than "natural", or the Medical Exami	ted	15. Decedent's E	ducation	16a	. Dece	dent's Usual Occup	oation			16b. Kind	of Business/I	ndustry	
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arylan(should be and Mental s marked o	2	Bruce Jackman 19a. Informant's Name/Relationship	(Type Print)	195	Maili	ng Address (Street		lable Pi		r City or T	own State 7	in Code)	
and 2 s and 2 s ealth an n 27 is ner trau			1,7,00. 1 7711.	100		Ashland P				1201	om, olalo, z	p 3 040)	
of Hear		Shirley Jackman 20a. Method of Disposition	_	20b. Place o	f Dispo	osition (Name of matory or other place					tion - City or	Town, State	
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Baltimore, Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event once.		21. Signatura of Funeral Service The	nse€Q	8	22	2. Name and Addre Fink Fune: 426 Crain				MD 21	1061		
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Hecords, P.O. Box 68/60, The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit.	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death		☐Ectopic pregnancy ☐ Other (specify)	у			230	d. Date of deli Month		'ear
s that	by Pr	Part II. Other significant conditions	contributing to death but	not resulting in	n the u	nderlying cause giv	en in Par	t I.	23e. Did to	bacco use	contribute to	the cause of de	eath?
COLDS W requires been sig should be									1 □ Y	es 2	No 3□Pr	obably 4XXU	Inknown
VITAI HECORDS, sician: The law requires to contificate has been signe irector, page 2 should be o	Completed								24a. Was a autop perfor		prior to death?	topsy findings a	ıvailable ıuse of
	a	25. Was case referred to medical					26. Pla	ce of Death	1 Yes (Check only or		1 ∐ Yes	2 No	
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	tion: T	27. Manner of Death 1 ★★Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day		Time o Injury	Wor	ry at rk? Yes 2[8d. Describe h	ow injury o	occurred		
LIVISION tall or Attending safter death. al Director: After din by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		y - At home, fa (Specify)	arm, sti	reet, factory, office		2	8f. Location (S City or Tow	treet and I n, State)	Number or Ru	ıral Route Numi	ber,
DIVI To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical	29a. Certifier (Check only one) CertifyIng P	hysician: To the best of miner: On the basis of e and manner state	my knowledge examination ar ed.	e, deat nd/or in	th occurred at the tile evestigation, in my o	me, date opinion, d	and place, a leath occurre	and due to the ded at the time, of	cause(s) ard date and p	nd manner as lace, and due	stated. to the cause(s)
To th within To th	Me	29b. Signature and title of certifier	ti Vo	fro	2	29c. Licens		r	2		signed (Monti		
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			10 Bradley Blv	-									
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 866 am THELMA **JACKSON** January Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death altimore naryland Greneral HOSPITAL Social Security Number 6. Sex Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8 Date of Birth **Funeral** Birthplace (State or Foreign Country) 1 □ M 2**X** F Months Hours Min 02-17-1919 Director 215-12-0845 92 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland Director 10d. Inside City Limits MD BALTIMORE 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 701 ARLINGTON AVE. 21217 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. Completed by 1 Never Married 2 Married filed within 72 hours after Yes 2 X No Baltimore, Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 🙀 No Specify "natural", 3 X Widowed 4 Divorced Specify: BLACK Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygier DOMESTIC HOUSEHOLD Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Page 1 and 2 should be 1 CHAS NEWMAN ROSIE THOMAS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 is i BALTIMORE, MD LEWIS COLEMAN/BROTHER 3838 ROLAND AVE. permit. Page 1 and 2 Department of Healt Important: If item 2 21211 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State injury 4 Donation 5 Other (Specify) Metro Crematory 01/25/12 Baltimore, MD 21. Sign than Funeral Service Licenses 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 1701-31 LAURENS ST. BALTIMORE, MD 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ oronary disease or condition resulting in death) Medical Due to (or as a cons - uence of) Examiner Sea year tirelly list our elities as Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or linjury been signed by the attending physician and should be detached for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy After this certificate Yes 2 No 1 Yes 2 No Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 1 No 1 🗌 Yes Other: ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending death. 2 \square No after death Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral D Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title certi 29d. Date signed (Month, Day, Year) · M 30, Name and address of pe son who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Steven Carl Kunze		partment of Health and Menta ertificate of Death	Hygiene 201	2 0187					
Physician	Decedent's Name (First, Middle,Last)		Date of Death Month Day Year	3. Time of Death					
Medical Examine			January 9, 2012	1215 hrs					
	Sacility Name (if not institution, give street and number) Sacrate Sa	4b. City, Town, or Location of D Ocean City	eath 4c. County of Death Worcester						
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs	If Under 1 Year If Under 2 Months Days Hours	4Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birt Min. Foreig	n					
Director	218-68-9723 1XM 2 F	56 Yrs. Months Bays Hours	Sept 21, 1955 col	^{intry)} Maryland					
any	Usual Residence of Decedent 10a. State 10b. County 10c. Ci	ty, Town or Location		10d. Inside City Limits					
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aryland Sa-f show at once.	Maryland Worcester 10e. Street and Number	Ocean City 10f. Zip Code	10g. Citizen of What Cour	itry?					
he Ma infed	307 Nautical Lane	21842	USA						
r death with the Maryland , or items 23s or 28s-f sho must be notified at once Funeral Director	11. Marital Status 12. Was Decedent Ever in	U.S. 13. Was Decedent of Hispanic Origin?	(Specify Yes or No- 14. Race - Americ	can Indian, Black,					
death or iter	1 Never Married 2 Married Armed Forces? 1 Yes 2 No	If Yes, specify Cuban, Mexican, Pu							
s after ral", o	or Dates:	1 Yes 2 X No specify:	Specify: Whi	*					
hours Fran	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	16a. Decedent's Usual Occupation (Give kind during most of working life. DO NOT use		ndustry					
5-0036 led within 72 hour sygiene. other than "natu the Medical Exan Completed	11	Houseman	Hote]	L					
S-00 ed wit sygien other he Mo	17. Father's Name (First, Middle, Last)		lame (First, Middle, Maiden Surname)						
17215-0036 Id be filed within 72 hours after femal Hygiene. sarked other than "natural", event, the Medical Examiner. De Completed by	Irvin Kunze		uanita Ulrich						
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-fath injury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	19a. Informant's Name/Relationship (Type, Print)		or Rural Route Number, City or Town, State,						
MC and 2 salth a sem 27	Irvin Kunze, Father 20a Method of Disposition 120b	. Place of Disposition (Name of cemetery,	Ocean City, Maryland Date 20c. Location - City or						
TOFE, ages 1 and of He it. If ite other to	1 Burial 2 Cremation 3 Removal from State	crematory or other place)							
Baltimore, permit. Pages I ar Department of Hee Important: If ite			01/25/12 Baltimore	, Maryland					
Balti permit. Departm Importu	21. Signature of Funeral Service Licensee Thomas Gree	Cremation Society	ty Of Maryland, Inc.	and 21228					
Physician	23a. Part I. Enter the disease, or complications that caused the dea	th. Do not enter the mode of dying, such as cardi	ac or respiratory arrest, shock, or heart	Approximate Interval					
/ /Medical	failure. List only one cause on each line. Immediate Cause (Final disease a, Pneumonia			Between Onset and Death					
:xaminer	or condition resulting in death) Due to (or as a consequence	of):							
-	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence	of)							
i i	cause. Enter Underlying Cause (Disease or injury that initiated								
Z g igi	events resulting in death) Last Due to (or as a consequence	o of):							
and and	UNPENDED AMENDED 23a, 27,	per me,g924 2-23-12 st	n						
50, tte be ex nysician burial	IF FEMALE: 23c. If yes, outcome of pre		23d. Date of delivery	_					
587 artifica ling pl	23b. Was decedent pregnant in the past 12 months?	2 Fetal death 3 Ectopic pro		ay Year					
b, Box 6876 the death certificate by the attending phy ched for use as the Physician/M	1 Yes 2 No 9 Unknown 9 Unknown	death 5 Other (Specify)							
	Part II. Other significant conditions contributing to death but not	t resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to t	he cause of death?					
P.O. es that the igned by oe detach			1 Yes 2 No 3 Prob	ably 4 🗹 Unknown					
Records, P. The law requires the factor has been signed. Thate has been signed, page 2 should be d. Completed b.				opsy findings available					
e law te has ge 2 sl			performed? death?	ompletion of cause of s 2 No					
ital Recician: The Secrificate rector, page	25. Was case referred to medical	26.Place of Death (Ch		2 140					
f Vital Physician or this cert ral directo	examiner? 1 • Yes 2 No Hospital: 1 Inpatient 2	ER/Outpatient 3 DOA Other No.	ursing Home 5 Residence 6 🗹 Other:	Scene					
Of After I After I Uneral	27. Manner of Death 28a. Date of Injury (Month, Day, Year)	28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred						
ttendi death. ctor: y the f	1 A Natural 5 Pending 2 Accident Investigation	1 Yes 2 No							
Division of Vital Records, spiral or Attending Physician: The law requiremental brector: After this certificate has been sifilled in by the funeral director, page 2 should be Certification: To Be Completed	Suicide Could not be	home, farm, street, factory, office building, etc.	28f. Location (Street and Number or Run or Town, State)	al Route Number, City					
C Fill to be	4 Homicide								
Division of ' To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral Medical Certification: T	(Check only one) 2 Medical Examiner: On the best of my knowled	eage, death occurred at the time, date and place, and/or investigation, in my opinion, death occurr							
To COU	29b. Signature and title of certifier	29c. License number	29d. Date signed (Mon	th, Day, Year)					
	Carol Hallan	O.C.M.E.	January 10, 2012						
200	30. Name and address of person who completed cause of death (Ite	em 23a)							
Drb.		900 W. Baltimore Street, Baltimore	, MD 21223						
State Registra		ature							
DHMH 17 Rev 1/2001		ORIGINAL							
0015 0000	OCME	CINCINAL							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene $2 \cap$ 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 21. AMERISSA KOLIBER 2012 10:40P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4h City Town or Location of Death 4c. County of Death Keswick Baltimore None 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days Hours Greece Director 217-26-9081 103 January fo. 1909 Usual Residence of Decedent show 10b. County notified at 10c. City, Town or Location Director 10d. Inside City Limits 28a-f 1 XYes 2 □ No Maryland None Baltimore 10e. Street and Number 'n 10f. Zip Code 10g. Citizen of What Country? Examiner must be 23a Funeral 700 West 40th Street 21211 USA items death v 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 0. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes XX No Specify: If Yes, Give Year or Dates "natural", 3 X Widowed 4 Divorced Completed White intal Hygiene. ced other than "natura c event, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Agathokli Papastathi Caliopi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is George Koliber Son 5555 Heron Point Drive Naples, Florida 34108 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) Greek Orthodox Cemetery 01/28/2012 Baltimore, Maryland nature of Funeral Se 22. Name and Address of Facilitohn O Mitchell IV Funeral Services of Dulaney Valley 200 E. Padonia Rd. Timonium, MD 21093 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sici_n Jean disease or condition Medical resulting in death) he CArdiovascular Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to for as a cons Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Live Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death Day Year 9 Unknown 9 Unknown Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s has performed? Yes 2 No certificate 2 🗆 No 1 🗌 Yes hours after death.

Ineral Director: After this certific
d filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 No 1 🗌 Yeş Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury Accident Suicide Investigation Could not be 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier completed (Check the bestyof my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner Signature ar 29c, License number 2520 pleted cause of death (Item 23a) (Type, Print) Charles St. Balto. ml Z1204

DHMH 17 Rev 7/2009

State

Registrar

6 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Allan 1:24A M 01 Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death Health & Rehab. Center gethesda Montgomery . Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 206-40-2223 1 🕅 M 2 🗆 F Months Davs Hours Min (Month, Day, Nebraska Director "I932 June Usual Residence of Decedent Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, <u>the Medical Examiner must be notified at</u> 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 😾 No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20906 3852 Bel Pre Rd; Apt 9 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent [U.S. 11. Marital Status unk 14. Race - American Indian, Armed Forces? Black, White, etc. \$ 1 Never Married 2 Married Maryland 21215-0036 white 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify. Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupationun 16b. Kind of Business Industry un (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) unk unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk should be file and Mental F is marked of 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sl it of Health a If item 27 is Gregg Donald - friend 3203 Beech St NW; Washington, DC 20015 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) in State 4 Donation 5 Othe (Specify) Signature of Funeral Service Licenses de birector 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or ment failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
Un Know Immediate Cause (Final olow Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examir that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Chronic atrial fibrillation, 1 Yes 2 No 3 Probably 4 Unknown Completed Cereprovascula accident, dementia 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autonsy of Colon Cancer in Metastasis lung 5 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No the Hospital or Attending Physician; completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No 28b. Time of Certificate: 28d. Describe how injury occurred Natural injury 5 Pending ☐ Accident ☐ Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Chowde D43121

Registrar DHMH 17 Rev 7/2009

Box 68760

P.O.

Records,

Division of Vital

MD: 605 Main Street, Laurel, MD 20707

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Sign

CHOWDHURY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Reg. No. Z Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year LUG 0443 N Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Annapolis Anne Arundel Medical Center Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral 9. Birthplace (State or Foreign Months Days Hours Director 217-98-3944 1 🗆 M 2 🗷 F 82 June 16 1929 HI ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director Maryland Anne Arundel Pasadena 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 8149 Waterford Road 21122 USA ral", or items 2 I Examiner mus 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force 1 Never Married 2 Married Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after Yes Baltimore, Maryland 21215-0036 2 X No If Yes, Give Year or Dates 1 Yes 2 No Specify "natural" Specify: 3 Widowed 4 Divorced White Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natur
almy njury or other traumatic event, the Medical I
once. 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Household Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Frances Leo Attridge Lena Marie Pankratz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John G. Klug, Jr. 1116 Willow Brook Drive, Pasadena, MD 21122 (son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State
 Donation 5 ☐ Other (Specify) Jan. Glen Haven Cemetery 2012 Glen Burnie, Maryland 21. Signature FuneritSN 22. Name and Address of Facility Stallings Funeral Home, P.A. <u>3111 Mountain Road, Pasadena, MD 21122</u> 23a. Part 1. Enter the di shock, or heart fail that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. ease, or complic re. List only one Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of ADRTIC STENOSIS Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of HEROSCLERO SIS or Attending Physician: The law requires that the death certificate be executed burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician hed for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) in the past 12 months? Month Pregnant at time of death Day Year 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should Completed 1 Yes 2 No 3 Probably 4 Unknown HTN 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ည Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) eral Director: After this filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1. Natural 5 Pending 1 Yes 2 No hours after death. 2 Accident 3 Sulcide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State within 24 hours a the Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of cert 21438 2w who completed cause of death (Item 23a) (Type, Print) DEFENSE MD 4401 NNAPOLI ENTAM 445 31. Date filed (Month, Day, Year)

JAN 2 6 2012 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Charles Month /16/12 Physician/ J. Knofski 16:25 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Queen Anne's Emergency Center Oueen Anne's Queen Anne's ocial Security Number 216–36–6192 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign onth, Day, Year) 8/13/40 Country) **Director** 1 🕱 M 2 🗆 F 71 MD Usual Residence of Dece 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location Director 10d. Inside City Limits Kent Island MD Oueen Anne's 1 Yes 2 No 10e. Street and Number 200 Terrapin Grove, # 317 10f. Zip Code 10g. Citizen of What Country? 21666 Completed by Funeral USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc Army 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 60 - 621 ☐ Yes 2 X No Specify White 3 Divorced 4 Divorced Specify 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Laborer Construction Be 17. Father's Name (First, Middle, Last)
Frederick 18. Mother's Name (First, Middle, Maiden Surname)
Lois Fitzpatrick ပ္ Knofski 19a. Informant's Name/Relationship (Type, Print)

Juanita B. Knofski/Wife 195 Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) 200 Terrapin Grove, # 317, Kent Island MD 21666 20b. Place of Disposition (Name of cemetery, crematory or other place Ardent Crematory 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 1/19/2012 Hanover Maryland 4 ☐ Donation 5 ☐ Other (Specify) Victor P. Charles L. Stevens Funeral Home, 1 1501 E. Fort Avenue, Baltimore MD ature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or as a construence of) arter Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunal-transit Cause (Disease or injury iabete that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by № No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 XXVI 1 ☐ Yes 2 🗙 🗴 Xo Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 **XX**n Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) ည 1 Yes 1 ☐ Inpatient 2 ☐ TR/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at XXatural 5 Pending work Accident Investigation 1 🗌 Yes 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Medical 29b. Signature and title of certifier

29c. License number D40152

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)

1117

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Micki Kantrowitz, MD 1630 Main Street, Suite 101, Chester Maryland 21619

State Registrar

3 □

29a. Certifie (Check

only one

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State Amend Item 208 tate Registrar	e of Maryland ,02903 Cert	tificate of Dea	aith and N ath		giene Reg. No. 2012	01876
	Physicia	n/	Decedent's Name (First, Middle, Last)				2. Date of Dea	ath Day Year	3. Time of Death
-Q-	Medic		LORETTA D. K				01	13 2012	4128AM
	Examin	er	4a. Facility Name (if not institution, give street and		4b. City, Town, or Loca	4. 1	,	4c. County of Deatl	1
-	Euroval		University et Maryland 5. Social Security Number 6. Sex	7 Age (In vrs. last hirthday)	Baltinov If Under 1 Year If U	Jnder 24 Hrs.	8. Date of Birt	h a Rint	hplace (State or Foreign
	Funeral Director		241-62-9393 1 M 2 D	(F 71 Yrs.		ours Min.	(Month, Day	Year 40 Co.	intry) C
	MC .		Usual Residence of Decedent				7.70		
	ryland -f sho ied at	Director	10a. State 10b. County MD	10c. City, Town or Local BAUT IN					10d. Inside City Limits
	e Ma r 28a notifi	Dire	10e. Street and Number	DAUTIV	10f. Zip Code				1 X Yes 2 □ No
	/ith th		4128 BALFERN AV	ENUE	21213	ζ		10g. Citizen of What Co	untry?
	ems er mu	Funeral	11. Marital Status 12. Was	Decedent Ever in U.S. 13. W	as Decedent of Hispan	nic Origin? (Spe	ecify Yes or No-	14. Race - Amer	ican Indian.
9	or it	by F	1 U Never Married 2 U Married 1 1	d Forces? If	Yes, specify Cuban, Me	exican, Puerto	Rican, etc.)	Black, White	, etc.
8	urs af tural" al Exe	ted	Year	, Give 1 or Dates.	☐ Yes 2 KNo Sp	ресіту:		Specify: BL	ACK.
5	72 ho "na" r ledic	uple	15. Decedent's Education (Specify only highest grade comple	eted) (Give ki	ent's Usual Occupation and of work done during	g most of worki	ing	16b. Kind of Business I	
12	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Completed			NOT use retired) PERV 150 R	_		DEPT OF S SERV	ICES
þ	be filed v ental Hyg ked othe ic event,	Be	17. Father's Name (First, Middle, Last)			_	e (First, Middle,	Maiden Surname)	
ylar	d be Menta arked	오	PRESTON DUPREE		1	ILLIE	GORHA	M	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type, Print)					r, City or Town, State, Zip	
e, N	and 2 seed the seed t		LORIANN KNIGHT (D	AUGHTER) 2900	61BBONS	AVE.	BALTO,	MD. 21214	<i>L</i>
יסר	Page 1 ament of hant of hant; If ite		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal	from State 20b. Place of Dispos	atory or other place)	//01	24/2012	20c. Location - City or	Town, State RE, MD RALEYS PA
ij	artme artme ortani injury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	GREENMT	CREMATOR	7 723	12012	CHAIR FINE	CAT SUE PA
Ba	permit. Departr Importa any inju		V augh	Aun 4	905 YORK	ROAD	BATTO	, MO . 2/2	-17-
			23a. Part 1. Enter the disease, or complications t	hat caused the death. Do not enter					Approximate
Ç.	Physician/		shock, or heart failure. List only one cause of Immediate Cause (Final disease or condition	MSTROINTESTIN	non He inn	red D Ho	2- C		Interval Between Onset and Death
	Medical Examiner			e to (or as a consequence of):	TIC THON	WINGLEY !	TOTE.		
		7.	Sequentially list conditions, b.						
	ed sit	Examiner	if any, leading to immediate Cause. Enter Underlying Cause (Disease or iinjury	e to (or as a consequence of):				-	
	xecut	Exa	that initiated events c	e to (or as a consequence of):					
9	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	dical	d						
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Box 687	eath certifica attending p	ian/	23h Was decedent pregnant 23c. If yes	, outcome of pregnancy Live Birth 2 D Fetal death 3 D				23d. Date of deli	- /
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ord	requ been shoul	lete					24a. Was a	an 24b, Were aut	opsy findings available
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ion	I or Attending Ph after death. Director: After th I in by the funeral	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	lana of laine. At home forms	M 1 Tyes				
Division of Vital Records, P.O.	l or A after Direc	Cer	4 Homicide determined b	lace of Injury - At home, farm, stree uilding, etc. (Specify)	et, factory, office		28f. Location (S City or Tow	treet and Number or Rur n, State)	al Route Number,
	To the Hospital within 24 hours a To the Funeral I completed filled	edical	29a, Certifier 1 Certifying Physician: To t	he best of my knowledge, death oc	cured at the time, date	and place, an	d due to the car	use(s) and manner as sta	ted.
	he Ho in 24 he Fu ipleter	Med	(Check 2 \(\sum \) Medical Examiner: On the	e basis of examination and/or investigner: To the best of my knowledge, de	gation, in my opinion, de	eath occurred at	the time, date a	nd place, and due to the c	ause(s) and manner stated.
	Noith Voil 10 10 10 10 10 10 10 10 10 10 10 10 10		29b. Signature and title of certifier		29c. License num		_	29d. Date signed (Month	, Day, Year)
			111000 1140	nd	12/522	649	3	01/13/12	
)			30. Name and address of person who completed		•		44		
	Stat	A	AMEUA FIASTRO 31. Date filed (Month, Day, Year)	22 So GREEN 2. Registrar's Signature June 9. Jan	Z ST BA	icino	rce m	D 21201	
	Registra	r	31. Date filed (Month, Day, Year) JAN 2 6 2012	year B. park					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 1:30 P M Julian Anthony Kantorski Jan. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8176 North Boundary Road Dunda1k Baltimore Co. If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number Birthplace (State or Foreign Country) . Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) Months 217-38-3467 Director 1 X M 2 D F Yrs 70 Sept.3,1941 Maryland Usual Residence of Decedent show 10a. State 10d. Inside City Limits notified at 10c. City. Town or Location Director 28a-f 1 Yes 2 No MD Baltimore Dunda1k 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ò er than "natural", or items 23a of the Medical Examiner must be Funeral 21222 8176 North Boundary Road United States Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🔀 No Black White etc 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give 3€ Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. marked other thar umatic event, the M Elementary/Secondary (0-12) 12 Years College (1-4 or 5+) Heavy Equipment Operator Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Yolanda Guiliani Anthony Kantorski Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8176 North Boundary Road Dundalk, MD Karen Kantorski (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Holy Rosary Cemetery 1/26/2012 Baltimore, Maryland Donation 5 Other (Specify) 21. Signatur of Funeral Service License Duda-Racks funeral Home of Dundalk, Inc. Þ 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac an expiratory arrest check, or heart failure. List only one cause are each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph, sician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine burial-trar and that initiated events resulting in death) Last Due to (or as a consequence of): cate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be to thours after death.

Funeral Director: After this certificate has been signed by the attending physicis. P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Other (specify) Pregnant at time of death g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>6</u> 2 No 3 Probably 4 Unknown Division of Vital Records, 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 No 1 ☐ Yes 2 🖫 No 25. Was case referred to medical examiner? filled in by the funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No ပ 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 28d. Describe how injury occurred injury Natural 5 Pending Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical 29a. Certifier 1 🌌 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) 4116 E NORTHEREN PROS BO 31. Date filed (Month, Day, Year) State AN 2 6 2012 Registrar

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			For State	State of Maryland	Department of Health a Certificate of Death	, ,	0010 0107
			Registrar 1. Decedent's Name (First, Middle, L	astl	Certificate of Death	2. Date of Death	g. No. 3. Time of Death
	Physicia /Medic	al	Angela Bern	ett Mc Carty	- Newton 4b. Sity, Town, or Location of	JANUARY	Day 1, 2013 4,30 PM
	Examin	er	4a. Facilly Name (If not institution, g	SP TT L	DALTIMORE	,	4c. County of Death
F	uneral		Social Security Number 6.	Sex 7. Age (In yrs. last	42-11		9. Birthplace (State or Foreign Country)
	rector		595-20-18-08 Usual Residence of Decedent	1□ M 20 F 45	Yrs.	5-30-	
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ar dea	tems	une	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican,	in? (Specify Yes or No- Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
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5-00 2 hou	natura Ical E	ted	15. Decedent's (Specify only highest g		6a. Decedent's Usual Occupation	1	6b. Kind of Business/Industry
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and 2	m 27 i	4	James C. Newto			ods Way, W	indsor Will, mid
Baltimore, Dermit. Pages 1 ar Department of Hee	or of		20a. Method of Disposition 1 Page Burial 2 Cremation 3		of Disposition (Mane of etery, cremetory 400 mmate)	Date 2	0c. Location - City or Town, State
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Balti permit. Departr	any Ir	is d	augh C.	Leeve	5151 Paltimor	- IF 1.11 O.L.	
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Division or Attending	Direct I in by	Certification: To	4 Homicide determine		farm, street, factory, office	28f. Location (Stre City or Town,	eet and Number or Rural Route Number, State)
Division C To the Hospital or Attending P within 24 hours after death.	uneral	cal C	29a Certifier 12 Certifying F	Physician: To the best of my knowled	ige, death occurred at the time, date and and/or investigation, in my opinion, deat	d place, and due to the ca	use(s) and manner as stated.
the H	mplete	Medical	one) wiedtest 220	and manner stated.	29c. License number		
L wil	28		do digitable and lilla of certifier	Chitchella Min	DOOI9 4		ANUARY 24, 2013
			30. Name and address of person who	completed cause of death (Item 23)		. 7	The state of the s
)			DIANA H. GRIFF	178,41D, 900 C		JAKTIMORE,	MARYLAND SIBBO
	Stat Registra		31. Date filed (Month, Day, Year) JAN 2 6 2012	32. Registrar's Signature	Kel	_	
	- Sione		JAN & U ZUIZ	com p. you	700		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Item 4a per verb/dvr, g923,01/26/2012dhb

Reg. No. For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 17, 201^{Year} 8:30 PM S. Kenneth Mack Medical 4a. Facility Name (if not institution, give street and number, LLC Lden Kosher Homes, LLC 11500 Gainesborough Road 4b. City, Town, or Location of Death 4c. County of Death Examiner Potomac Montgomery If Under 1 Year I If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min Oct 5, Pay, Year 14 1 ▼ M 2 □ F Massachusetts 97 Director 150-07-0627 Usual Residence of Decedent show 10a. State 10b. County 10d. Inside City Limits with the Maryland 10c. City. Town or Location notified at Director 28a-f 1X Yes 2 No Bethesda Maryland Montgomery 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? ö must be n Funeral U.S.A. 20814 5422 Moorland Lane items and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14 Bace - American Indian 11. Marital Status Examiner Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ō ğ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 ⅓ Widowed 4 ☐ Divorced White "natural" Completed th and Mental Hygiene.
27 is marked other than "natur traumatic event, the Medical | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) Mack Drugs Co. Executive Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Jennie Foor Jacob Maistrovsky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important; If item 27 is any injury or other trau Julie Mack (Daughter) MD 20814 5422 Moorland La., Bethesda, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Page 1 cemetery, crematory or other place)
Beth El Cemetery 1X Burial 2 Cremation 3 Removal from State Twp of Washington, NJ 1/20/2012 4 Donation 5 Other (Specify METROPOLITAN FUNERAL SERVICE, 5517 VINE STREET, ALEXANDRIA, 21. Signature of Funeral Service 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Saque titally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Physician/Medical Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Due to (or as a consequence of): $Aq_{1}/Ce^{-4}\mathcal{I}_{e}$ Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Month 5 Other (specify) Pregnant at time of death signed by the al d be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown cathhas keen sig ; page 2 should k Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy To the Hospital or Attending Physician: The Is within 24 hours after death.

To the Funeral Director: After this certificate h 2**X** Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) completed filled in by the funeral Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 🗌 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29c. License numb 29d. Date signed (Month. Day, Year) 18

State Registrar 30. Name and address of person who come

Raffel,

JAN 2 6 2012

M.D.

5413 W. Cedar La., Bethesda, MD 20814

ise of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 201^{rea} 2:48 PM M Bonnie L. McQuait January 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington 7 E. Washington Street #604 Hagerstown 5. Social Security Number unk 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) unk 7. Age (In yrs. last birthday) 8. Date of Birth Hours July 9 , 49956 55 1 □ M 2 🛣 F 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Tes 2 X No Hagerstown Washington

10g. Citizen of What Country?

14. Race - American Indian, Black, White, etc.

Specify: white

16b. Kind of Business/Industry unk

USA

18. Mother's Name (First, Middle, Maiden Surname) unk

STE101 HAGGISTARIN, US

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10f. Zip Code

life. DO NOT use retired)

21740

1 ☐ Yes 2 X No Specify:

16a. Decedent's Usual Occupation unk (Give kind of work done during most of working

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified as once. Baltimore, Maryland 21215-0036 Be မ Ph_sician/ Medical **Examiner**

Physician/

Medical

10a. State

MD

10e. Street and Number

11. Marital Status unk

unk

1 Never Married 2 Married

3 Widowed 4 Divorced

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last) unk

19a. Informant's Name/Relationship (Type, Print)

7 E. Washington St; Apt 604

15. Decedent's Education (Specify only highest grade completed)

If Yes, Give Year or Dates

College (1-4 or 5+)

unk

Director

Funeral

þ

Completed

Examiner

Funeral

Director

ms 23a or 28a-f show

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and for use as the burial-tran s certificate has been signed by the attending physician director, page 2 should be detached for use as the buria Physician/Medical 2ر| completely filled in by the funeral Medical Certificate:

Division of Vital Records, P.O. Box 68760

	llagerscown rolle	e Deparement	JO N. Bullia	ms nrvu,	nagers	cowii, rid 21	1.740-4090				
1	20a. Method of Disposition		ace of Disposition (Name of		Date	20c. Location - City	or Town, State				
	1 Burial 2 Cremation 3 R 4 Donation 5 X Other Specify	iemovar nom state	metery, crematory or other plac	"							
	21. Signature of Funeral Service Livers	La Beace	22. Name and Addres	SE:	ate Anat	omy Board					
Į	www.	Ave Director				ltimore, M	D 21201				
-	23a. Part 1. Enter the disease, or complic	cations of t caused the deat.	Do not enter the mode of dving	such as cardiac	or respiratory an	rest	Approximate				
	shock, or beart failure. List only one Immediate Cause (Final	cause in each line.	4	/		,	Interval Between				
1	disease or condition resulting in death)	Hure	MUCANDIA	PAPATIC	Tron		$MNUT(\varphi)$				
	resulting an death)	(or as a conseque	nce (f):	2 2			C4.				
	Sequentially list conditions, b	(016NA19	HATCHY VI	SUME			J 7 CAns				
2	if any, leading to immediate cause. Enter Underlying	ue to (or as a conseque		1 - 5			4 11 -				
	Cause (Disease or injury	1)(B) GR	ineutus.	91E C			207 CANS				
ì	resulting in death) Last	Due to (or as a conseque	nce of):			· -					
2	C d										
,	IF FEMALE: 23b. Was decedent pregnant 23	Bc. If yes, outcome of pregnance	су			22d Date of d	lalivan				
3	in the past 12 months? 1 Live Birth 2 Fetal death 3 Ectopic pregnancy Month Day Year										
, y 3	1 Yes 2 No 9 Unknown	9 Unknown	a o = oo. (op oo)/ =								
	Part II, Other significant conditions conf	tribu y ing to death but not result	ting ip the underlying cause giv	en in Part I.	23e. Did to	obacco use contribute	to the cause of death?				
2	[WOENTENCON]	15PHADTIC	SYNDRAM	9	1 1 1	Ves 2 No 3	Probably 4 🗆 Unknown				
1	7	No Track	16								
2	()(A.KETC NEPT	thocatte +	tupen11010	MIA	24a. Was	osv prior to	autopsy findings available completion of cause of				
5					perfo	ormed? death?	es 2 No				
3	25. Was case referred to medical examiner?		26. Pla	ce of Death (Che		/					
	1 Yes 2 No	ospital:	R/Outpatient 3 DOA Othe		ome 5 X Resid	dence 6 Other (Spe	ecify)				
:	27. Manner of Death	28a. Date of injury 2	8b. Time of 28c. Injury	at		now injury occurred	, , , , , , , , , , , , , , , , , , , ,				
	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury work'	es 2□No							
	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom	ne, farm, street, factory, office		28f. Location /9	Street and Number or R	Jural Route Number.				
3	4 - Hornicide determined	building, etc. (Specify)	·		City or Tow						
3	29a. Certifier 1 Certifying Physic	ian: To the best of my knowler	dge, death occurred at the time	date and place	and due to the co	ause(s) and manner as	stated				
3	(Check 2 \(\sum \) Medical Examine	r: On the basis of examination a	and/or investigation, in my opinior knowledge, death occurred at the	n, death occurred a	at the time, date a	and place, and due to the	e cause(s) and manner stated.				
	29b. Signature and the by certifier	A CONTROL TO THE BEST OF THE	29c. License			29d. Date signed (Mon					
	► 118-11/1 E	to a Person	(10)	11717-		1/72/7	615				
	1/W III W	1MULT 197411	400	11/40) . !	114116	12				

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ January 13, 2012 3:10 Ам Peter Henry Madera Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Joseph Richey Hospice If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Oct 30, 79944 Maryland 218-42-3087 **Director** 67 1 X M 2 🗆 F Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at rector 1X Yes 2 No MD Baltimore $\bar{\Box}$ 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? must be r Funeral 21230 USA 2043 Griffis Ave. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces? Black, White, etc. ō þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: white If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify: "natural" 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) er than Elementary/Secondary (0-12) College (1-4 or 5+) unk unk pipe coverer is marked other aumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Peter H. Madera Jr. Betty Madera If item 27 is marke or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2509 Dulany St; Baltimore, MD 21223 Linda Madera - wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any injury or o Burial 2 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, Other (Specific 22. Name and Address of Facility State Anatomy Board 201 655 W. Baltimore St; Baltimore, MD 21201 rt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between ck, or heart failure. List only Immediate Cause (Final disease or condition Ph_sician/ 3 Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or do a consequence of). Exami signed by the attending physician and id be detached for use as the burial-tran Madera that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Fctopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Dav Year Pregnant at time of death Yes L _ Unknown 9 Unknown Hospital or Attending Physician: The law requires that 124 hours after death. Funeral Director. After this certificate has been signed b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 □ Unknown After this certificate has been significate has been significated and a should I Were autopsy findings available prior to completion of cause of death? 24a. Was an Yes completely filled in by the funeral director, Be 25. Was case referred to mexaminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence ဂ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Matural 5 Pending work?
1 Yes 2 No Accident
Suicide Investigation 6 Could no 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide deter Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only one) 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 06-2011

State Registrar

1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 22 per fh g923 1-26-12 vt
State of Maryland 7 Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 836 Januare Physician/ Kevin M. Moore, am Medical 4c. County of Death N/A4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death mary/and Hospital Greneral Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday)
24 yrs. 8. Date of Birth (Month, Day, 12/6/8 9. Birthplace (State or Foreign **Funeral** 1 ÅM 2 □ F Min. 218-19-1267 Months Hours Country)
MD **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County N/A 10a. State 10c. City, Town or Location Baltimore 10d. Inside City Limits Director MD Yes 2 No 10f. Zip Code 21217 10g. Citizen of What Country? 10e. Street and Number 1213 W. Madison Ave Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, African 1 X Never Married 2 ☐ Married Completed by 1 Yes If Yes, Give 2X No Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: 3 Widowed 4 Divorced Amer. Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Education College (1-4 or 5+) Student Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kevin M. Moore, Sheila E. Summerville 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2528 Frederick Ave, Balt., MD 21223 Crystal Moore/Sister 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2x Cremation 3 Removal from State Bayview Crematory 2/2/12 Balt., MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of/Funeral Sep e Licens 22. Name and Address of Facility Hari P.Close F.Svc, PA 5126 Belair Rd. Baltimore, Md. 21206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner tension Sequentially list conditions, Examine If any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury (or s a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month the detached been signed by to should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? death? this certificate 2 1 No 1 Yes director, 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at After t 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be Accident 24 hours after deat Funeral Director; Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check within 2 To the I only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Swite 407 Baltimore, MD. 21201 N. Eutaw nachala 31. Date filed (Month, Day, Year)

JAN 26 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month PM Innuar 4:20 201 Patrick W. Moyer Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner J. Griveri 8. Date of Birth (Month, Day, Ye April 06 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 🔀 M 2 🗆 F Days Hours Min. Country) 216-42-8670 Yrs. Director 66 MD Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director Maryland Anne Arundel Pasadena 1 Yes 2 X No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a 428 Royal Beach Road 21122 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Was Decedon. _ Armed Forces? 1 ☐ Yes 2 😾 No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Maintenance Mechanic Industrial 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve ပ William W. Moyer Alberta Ruth Woodward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elaine Kreinheder (daughter) 1517 Puffin Court, Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Jan. 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Metro Crematory Inc. Baltimore, Maryland 2012 21. Signature of Funeral 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. 23a. Part 1. Enter the disease, or con Jure. List only Approximate Interval Between shock, or heart fal Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): nding physician use as the burial Physician/Medical P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for 5 Other (specify) Month Day Year Pregnant at time of death signed by the a d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed certificate 1 Yes Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 0 No 1 Tyes 1 KInpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ this 28a. Date of injury (Month, Day, Year) the funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at After 1 🖎 Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director: A Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 29a. Certifier 💫 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 32 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 D 32. Regis State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 22 2012 2:10 A January Edna Marie Antoinette Magenhofer Medical 4a. Facility Name (if not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Summit Park Health and Rehab. Center Baltimore Catonsville 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Days Hours (Month, Day, Year) **Director** 215-07-6115 1 M 2XXF 105 Dec. 20,1906 Maryland Usual Residence of Deceder or 28a-f shov 10a. State 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director MD Baltimore Halethorpe 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21227 5539 Oregon Avenue . Page 1 and 2 should be filed within 72 hours after death with USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2XXNo Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", 3 Divorced 4 Divorced event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) of Health and Mental Hygiene. item 27 is marked other than " other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Manager/Securities Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 George Magenhofer Edna Hauck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Earl Magenhofer-Nephew 513 Random Road, Baltimore, Maryland 21229 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. Date 4 ☐ Donation 5 ☐ Other (Specify) Lorraine Park Jan. 28, 2012 Woodlawn Maryland 22. Name and Address of Facility Am rose Funeral Home Inc. Signature of Funeral Service License 1328 Sulphur Spring Road Arbutus Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between DEMENTIA Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) NICHOLM Medical Due to (or as a consequence of): **Examiner** SENILIT UN KNOWN Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as t nding IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 C Ectopic pregnancy for 1 Pregnant at time of death 5 Other (specify) Month Day Year 1 Yes 2 No ed by the a detached 1 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 Yes 2 No Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital: Other: မ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work?
1 Yes 2 No s after death. М Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hou To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D005354 8 ATTENDING 2012 JAN

State Registrar

BV

DHMH 17 Rev 06-2011

WILKEND AVE

21275

RALTIMORE

#204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

TANSING 4

31. Date filed (Month, Day, Year)

2 6 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 0459 PM Deryl Michael O'Briant 2012 January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hospital of Baltimore Baltimore City Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours 216-80-1875 **Director** 1 XM 2 🗆 F 07/20/1960 North Carolina 51 Yrs Usual Residence of Decedent 28a-f show 10d. Inside City Limits aţ 10a. State 10c. City, Town or Location Director traumatic event, the Medical Examiner must be notified 1 XYes 2 No MD n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? and Mental Hygiene. is marked other than "natural", or items 23a Funeral 4305 Pimlico Road Apartment 2 21215 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 1 X Never Married 2 Married þ 1 ☐ Yes 2 X No If Yes, Give X Year or Dates. Specify: Black Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Specify: Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 1 Dementary/Secondary (0-12) College (1-4 or 5+) Concrete Finisher Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sidney Oliver Brooks Rose Marie O'Briant 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is 1 any injury or other traum once. Hermetta Woodard-Fiance 4305 Pimlico Rd Apt 2 Baltimore, MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Durial 2 Temation 3 Removal from State 1.23.2012 Hanover, MD ☐ DonAtion 5 ☐ Other (Specify) Ardent Crematory John L. Williams Funeral Directors, 4517 Park Heights Ave Baltimore, MD Par 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Patient Immediate Cause (Final hemornage Physician/ Brainstem 1 day disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 2 days pertension sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine anding physician and use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy in the past 12 months? Dav Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> Diabetes Mellitus 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed Hyperlipidemia 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 s certificate has the director, page 2 s 25. Was case referred to medical funeral director, To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No n 24 hours after death. e Funeral Director: Aft etely filled in by the fu 2 Accident Investigation 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 🗆 within 2 29b, Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Romenta RES-000 13,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rutha Mewa , MBBS Sun lov MBBS Hospital of Balhmore 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 06-2011

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 January 3:44 P William Peters Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince Georges 6916 Hanover Pkwy Unit 100 Greenbelt If Under 1 Year | If Under 24 Hrs. Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days 218-36-7039 **Director** 1 🗙 M 2 🗆 F 71 Jan. 14,1941 Maryland Usual Residence of Deceden 28a-f shov with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2 No Greenbelt MD Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 69<u>16 Hanover Pkwy</u>. Unit 100 20770 Inited States Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify: Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. United States Elementary/Secondary (0-12) College (1-4 or 5+) Horicultural Engineer Government 12 Years Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ Robert G. Peters, Sr. Ruth A. Aspinall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Diane Peters (Sister In Law) 7918 Kavanagh Road Dundalk, Maryland 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 🔀 Burial 2 🗀 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 1/25/2012 Baltimore, Maryland of Funeral Service Licer Signat/r Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease of complications that cause shock, or heart failure. List only one cause on each lin ne disease complications that caused the death. Do not enter the mode of dying, such as cardiac or resulatory arrest Approximate Interval Between Onset and Death Immediate Cause Final disease or condition Ph_sician/ **Medical** resulting in death) a consequence of Examiner quentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). I or Attending Physician: The law requires that the death certificate be executed after death. the burial-trai Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for in the past 12 months? Year Month Day signed by the at d be detached for Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available 24a. Was an has page 2 prior to completion of cause of death? autopsy 00 eral Director: After this certificate I filled in by the funeral director, pag 2 🗌 No Yes 1 Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) 21 No Hospital Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manuer of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending Natural injury 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined within 24 hours the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29d. Date signed (Month, Day, Year, 30. Name and address of persor oleted cause of death (Item 23a) (Type, Print) 20910 m1) Spring Date filed (Month, Day, Year 32. Registr State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 4 3. Time of Death . Decedent's Name (First, Middle, Last) 2 Date of Death Month Year 1050 PM 2012 Anna Petrovia 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death FRANKLIN Square Hospital Baltimore Rosedale If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number Months Days Hours (Month, Day, Year) 191-26-0035 1 🗆 M 2 🗶 F Pennsylvania July 4,1920 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Baltimore Essex 1 Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 924 Mace Avenue 21221 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. ☐ Yes 2 XNo 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 ▼ Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home 10 years Housewife 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Tecla Barritzka Peter Romanik 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louis Petrovia son 7900 St. Claire Lane, Dundalk, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Januarv 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Baltimore, Maryland Bayview Crematory 26, 2012 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 23a. Part 1. Enter the disease, shock, or heart failure. Is complications that caused the death to not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death with StanhyLococcus Gureus bacteremia disease or condition resulting in death) uninary tract infection Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Ejection Fraction with Cardio my opathy Due to (or as a consequence of): infarction a myocardial 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Month Day Year Pregnant at time of death Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an

Ph_{sician/} Medical Examiner

Physician/

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Department or Important: If any injury or once.

of Health

with the Maryland

Baltimore, Maryland 21215-0036

and burial-tran attending physician for use as the buria igned by the at be detached for signed by page 2

Hospital or Attending Physician: The law 24 hours after death.

Funeral Director: After this certificate has filled in by the funeral director, To the Hospital within 24 hours a To the Funeral Completely filled

Division of Vital Records, P.O. Box 68760

Examine Medical

Physician/Medical Completed by Be မ

Certificate:

(Check

only one)

3 🗌

anna

29b. Signature and title of certifier

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State Registrar

resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

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death?

2 No

autopsy performed

1 ☐ Yes 2 ☑ No

City or Town, State)

BaLTO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRANKLIN SQUETE DR DR Danna Doratatad 9000

31. Date filed (Month, Day, Year)

JAN 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Day 19 JÄNUARY 2012 10:50 **GEORGE** QUEEN JR. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 10205 BUENA VISTA AVENUE LANHAM PRINCE GEORGE'S If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthdav) **Funeral** Months Days Hours Min 1 X M 2 □ F JUNE 1943 WASHINGTON, DC Director 68 <u>579-54-4095</u> Usual Residence of Decedent show 10a. State 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MDPRINCE GEORGE'S LANHAM 14 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 10205 BUENA VISTA AVENUE 20706 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Black, White, etc. 1 Never Married 2 X Married by ☐ Yes 2 X No Baltimore, Maryland 21215-0036 hours after BLACK If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th MAIL CLERK PRIVATE e 1 and 2 should be filed wit t of Health and Mental Hygie If item 27 is marked other or other traumatic event, tt Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 2 GEORGE T. QUEEN SR. HELEN MILES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10205 BUENA VISTA AVENUE LANHAM, MARYLAND 20706 BARBARA QUEEN/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) RIVERDALE CREMATORY 1/24/2012 RIVERDALE, MARYLAND 4 Donation 5 Other (Specify) J. B. JENKINS FUNERAL HOME, INC. 21. Signature Juneral Service Licenses 22. Name and Address of Facility 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ METASTATIC LUNG CANCER disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) -transit Exami Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of) nding physician use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten for u 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death the ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 X Yes 2 No 3 Probably 4 Unknown Completed been si should I 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has page 2 s performed this certificate 2 No 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 🗌 Yes 2 XNo ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 X Natural 5 Pending after death.

Director: Aft
d in by the fur Accident 1 Tes 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours at To the Funeral D completed filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) D27521 JANUARY 20, 2012

DHMH 17 Rev 7/2009

State Registrar KADIE E. LEACH M.D. 9500 ANNAPOLIS ROAD SUITE A1 LANHAM, MARYLAND 20706

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month/20/2012 Leora Marie Reynolds 11:00am M Medical Facility Name (if not institution, give street and number)
Charles County Nursing & Rehab Center **Examiner** 4b. City, Town, or Location of Death 4c. County of Death
Charles LaPlata ocial Security Number 473-09-3321 If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 94 **Director** 1 □ M 2**X**F 8/20/17 Yrs show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 10d. Inside City Limits Maryland Charles LaPlata 1 Yes 2 X No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 10200 LaPlata Road 20646 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married b Yes 2 XXo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XX o Specify White Specify: 3XXWidowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Charles Hohn Wilhelmina Schultz 19a. Informant's Name/Relationship (Type, Print)
Carl Reynolds / Son Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip C 10708 Cedarwood Drive, Waldorf MD 20601 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State Department of Important: If i any injury or o once. 1 🗆 Burial 2 🗀 Cremation 3 🔀 Removal from State Oakwood Cemetery 1/27/12 Mora, 4 Donation 5 Other (Specify) Stevens Funeral Home, 21. Signature of Funeral Service Licensee Victor P. Charles L. Stevens Funeral Home 1501 E. Fort Ave Baltimore MD Doda 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on wach line Immediate Cause (Final - Ph, sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Ectopic pregnancy Month Pregnant at time of death Dav Year significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PERTIENSION 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform Yes 2 N 2 🗌 No 1 🗌 Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No 1 Tes Other: မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at work? 28d. Describe how injury occurred Funeral Director: After Natural 5 Pending 1 Yes hours after death Accident Investigation Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 30. Name and a pleted cause of death (Item 23a) (Type, Print) 2070 010 State Registrar

James Rice 12-00524 Unk Unk

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

ONK ONK		- For State	State of	Marylanu /		tificate of L		iu ivieritai		g. No. 2 (012 0189
Physician	1	e gistrar I. Decedent's Name (First,	Middle,Last)		-				Date of Deat Month	Day Year	3. Time of Death 2202 hrs
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		a. Facility Name (if not in: 4300 Cedar Gard		eet and number)			Baltimore	Location of D	eaui	-re. County of	55341
Funeral	- (. Social Security Number	6. Sex	7. Age	(In yrs. la	ast birthday)	If Under 1 Ye	ar If Under 2	4Hrs. 8. Date of Bir		9. Birthplace (State or
Director		217-39-339		2F	18	Yrs.	Months Da	ys Hours	Min. 08]	L6 93	Foreign Country) MD
kus	_	Jsual Residence of Deced 0a, State 10b. Co			10c. City,	Town or Location					10d. Inside City Limits
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th the Maryland 23a or 28a-f sho notified at once.		4911 Frede						1229		U.S	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once. To Re Commissed by Finneral Director		Marital Status Never Married 2		Was Decedent Armed Forces?	_				' (Specify Yes or No uerto Rican, etc.)	- 14. Race - White,	American Indian, Black, etc.
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica		ames Rice	Sr.						Stevens		
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876 tificate ng phy as the h	2	F FEMALE: 3b. Was decedent pregna		3c. If yes, outcom	e of preg		death 3	Ectopic pr	regnancy	23d. Date of d Month	Day Year
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Division o spital or Attending spous a fer deat. neral Director: Aft filled n by the fune		3 Suicide 6 4 ✓ Homicide	Could not be determined	(Specify) Par	k/Recre	eation Area			or Town, S 4300 Cedar C	State) Barden Road, Ba	altimore, MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after dark for the Fameral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitional Certification: To Be Completed by Physician Medical Experimental Certification:		29a. Certifier 1 Certify cone) 2 Medic	al Examiner:On	the basis of exar	knowled	ge, death occurre	d at the time, n, in my opinio	date and place, on, death occur	, and due to the caus red at the time, date	se(s) and manner a and place, and du	as stated. ie to the cause(s)
To wit	ğ	29b. Signature and title of		d manner stated.	71	124	29c. Licer	nse number		29d. Date signe	d (Month, Day, Year)
		(lector	Ville	Nee	the -	100	0.0	C.M.E.		January 19,	2012
2	t	30. Name and address of					Baltim ===	Street Dell	imore MD 242	23	
2		Victor Weedn MD		32. Registra			-aiumore	Sueet, Balt	imore, MD 212		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 0 | 8 9 2 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ January 25 2012 Leo Joseph Sydlik 2:20 A^{M} Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Timonium Baltimore 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** 220-20-3842 Director 1 ▼M 2 □ F 83 July 4, 1928 Maryland Usual Residence of Decedent 28a-f shov 10h County 10c. City, Town or Location 10d. Inside City Limits Director must be notified 1 Yes 2X No Parkville Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 9043 21234 Navgal1 United States 12. Was Decedent Ever in U.S.
Armed Forces?
1 ▼Yes 2 □ No 1950
If Yes, Give
Year or Dates, -1953 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No Specify 3 Widowed 4 □ Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Laborer/Machine Operator Western Electric Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname, P Ignacy Sydlik Katarzena Kmiotek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynn Papa / Daughter 9043 Naygall Road, Parkville, Maryland 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Metro Crematory Inc. 01/25/2012 | Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee ${
m Alyson}\,\,\,{
m K}$ 22. Name and Address of Facility Cremation Society of Maryland Taylor 299 Frederick Road, Baltimore, Maryland 21228 Part 1. Letter the disease, or compileations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ CEREBROVASCULAR ACCIDENT disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of) that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 the Hospital or Attending Physician: The law requires that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ 1 Live Birth
4 Pregnant Month Pregnant at time of death 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 2 X No Be 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) 1 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 NO Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending injury 1 Yes 2 No Investigation 6 Could not be Accident Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 2012 person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

JACKIE JONES,

31. Date filed (Month, Day, Year)

CRNP

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

32. Registrar's Signatur

Scott, Laura perhent known as

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Maryland	⊆ ⊆ s ⊐	14	19a. Informant's Name/Re	elationship (Type	e, Print)	, 1	9b. Mailing A	ddress (Street	,		ute Number,	City or	Town, State,	Zip Cod	e)
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Baltimore,	Page 1 nent of ant: If it ary or o		1 ☑ Burial 2 ☐ Cre	mation 3 🗆 R	emoval from State	ceme	tery, cremate	or other plac	re)	-86		73	ocation - City		State
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Division of Vital Records, P.O. Box 6876	requires that the death certificate been signed by the attending phy should be detached for use as the	Physician/Medi	IF FEMALE:		- 15										
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	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check 2 L Me	dical Examine		examination and	or investigat	ion, in my opinio	n, death occu	irred at the	time, date an	d place,	and due to the	ne cause(s) and manner stated
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DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Simmo :59 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death nove 8. Date of Birth If Under 24 Hrs **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State of Foreign 1 M 2 F Months Washington DC **Director** Yrs. 216-20-1960 83 1928 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ty Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 710 N. Monroe St. 21217 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? 1 X Yes 2 No 1945 If Yes, Give Year or Dates. 1949 Black, White, etc. ò 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 black. 1 ☐ Yes 2X No Specify: Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) truck driver Giant Bakery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Albert Simmons Lucy Mae Crawford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3928 Cedar Dale Rd; Baltimore, MD 21215 Dolores Simmons - wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) 22. Name and Address of Facility State Anatomy Board Irector 655 W. Baltimore St; Baltimore, MD 21201

Ph_sician/ Medical Examiner

> inding physician and use as the burial-trans signed t within 24 hours after deat To the Funeral Director: completed filled in by the

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

	23a. Part 1. Enter the disease, or com shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	nplications that caused the death. Do not enter to one cause on each line. a		or respiratory arrest,		Approximate Interval Between Onset and Death
dical Examiner	Sequentially list conditions, it any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	b. Due to (or as a consequence of): d.				
Iysicidii/ivie	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		ctopic pregnancy hther (specify)		23d. Date of de Month	livery Day Year
ered by r		contributing to death but not resulting in the und		1 ☐ Yes	2 □ No 3 □ P	the cause of death?
		·		24a. Was an autopsy performed?	prior to death?	topsy findings available completion of cause of
2	25. Was case referred to medical examiner?		26. Place of Death (Check	only one)		
2	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	3 DOA Other: 4 Nursing Ho	me 5 🗆 Residence	6 ☐ Other (Spec	eifv)
llcare.	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation			28d. Describe how inju		
5 6	3 Suicide 6 Could not b		, factory, office	28f. Location (Street a City or Town, Stat	nd Number or Ru e)	ral Route Number,
NICOIN.	(Check 2 L Medical Exam	sician: To the best of my knowledge, death occ iner: On the basis of examination and/or investiga se Practioner: To the best of my knowledge, dea	tion, in my opinion, death occurred at	the time, date and place	e, and due to the	cause(s) and manner stated.
	29b. Signature and title of certifier		29c. License number	29d. D	ate signed (Month	h. Dav. Year)

72750

Baltimere

19,2012

State Registrar M.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2000 W.

Stah

Kathryn

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ J PINVARY 2072 Shedrick Junior Smith 8:38 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death AGNES HOSPITAL BALTIMORE If Under 1 Year I If Under 24 Hrs. 9. Birthplace (State or Foreign County) Social Security Number 226 – 78 – 1661 7. Age (In yrs. last birthday) Funeral 8. Date of Birth Min. Months Days 6/13/59) Director Usual Residence of Decedent 10b. County N/A show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examiner must be notified at once. 10a, State 10c. City, Town or Location Baltimore 10d. Inside City Limits Director MD 1 Yes 2 No 10e. Street and Number 211 Atholgate Lane - Apt. B 10f. Zip Code 21229 10g. Citizen of What Country? Funeral [12. Was Decedent Ever in U.S. Armed Forces? 1 🗷 Yes 2 🗍 No. If Yes, Give 1 977-83 Year or Dates. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, African Specify: Amer. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Three Brothers Warehouse Elementary/Seconday (0-12) College (1-4 or 5+) Laborer Be 17. Father's Name (First, Middle, Last)
Charles Smith 18 Mother's Name (First, Middle, Maiden Surname) Gladys Smith 19a. Informant's Name/Relationship (Type, Print)
Shedrick A. Smith/Son Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 34 Peach St., Balt., MD 21230 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1/28712 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bay view Commatory 4 ☐ Donation, 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22 Name and Addr Yof FacilityHari PtClose 2F2Sys PA 5126 Belair Rd, Balt., MD 2F2Sys 57A5 23a. Part L'Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final NYOCARDIAL INFARCTION Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to jor as a consequence of Cause (Disease or iinjury that initiated events and -trar Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical To the Hospital or Attending Physician: The law re juires that the death certificate be ewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial completed filled in by the funeral directo; page 2 shr jud be detached for use as the burn Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacce use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 1 ☐ Yes 2 ☑ No ☐ Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iours after death.

Increal Director: A

filled in by the fu 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year) 00051865 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12172603 CURTIS HUSPITM2 21229

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last 2. Date of Death 3. Time of Death Physician/ an Medical 4a. Facility Name (if not institution give street and number) Examiner 4c. County of Death Medi IMOY Social Security Numbe 6. Sex If Under If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 220-20-5887 1 XM 2 D F **Director** 83 Feb. 14, Maryland Usual Residence of Deced show at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director must be notified 28a-f MD 1 Yes 2 No Anne Arundel Linthicum 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 111 Sycamore Road 21090 USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Examiner Armed Forces?
1 4 Yes 2 No Black, White, etc. 2 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: White Yes. Give "natural", 3 Widowed 4 Divorced Completed Year or Dates Jr than "he... "he Medical F 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) other traumatic event, the Statistician Marketing Railroad other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be file of Health and Mental Fitem 27 is marked or ပ္ Dr.William H. Stewart Anna Elizabeth Cashour 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sycamore Road Linthicum Maryland 21090 Lois Stewart-Wife 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of I Important: If its any injury or of 1 X Burial 2 Cremation 3 Removal from State Central Cemetery Jan. 26, 2012 New Market Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home Inc. 21. Signature of Funeral Service License Sulphur Spring Road Arbutus Maryland 21227 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1 Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ neart disease or condition Medical resulting in death) Examiner WU arter Sequentially list our title as if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami and -trai Due to (or as a consequence of) attending physician I for use as the buri Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 1 Yes 2 L 9 Unknown the þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. n signed I 23e. Did tobacco use contribute to the cause of death? ور ک 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed? Yes 2 No certificate __ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No 1 Yes ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) I Director: After to d in by the funera Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending Accident Investigation 6 Could not be □ Accider
 □ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined hours after City or Town, State) 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hou

To the Funel

completely fi 29a. Certifier To the h Certifying Nurse Practitioner To the best of my knowledge 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who con 211V mpleted cause of death (Item 23a) (Type, Print) 10 North Greene athenine Schrenk

DHMH 17 Rev 06-201

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 3. Time of Death Physician/ Jan. Smith 20°1 4:40P Wayne Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Baltimore Gilchrist Hospice Center Towson If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth 1 □XM 2 □ 04-17-51 214-58-6209 60 **Director** MD Usual Residence of Decedent show filed within 72 hours after death with the Maryland al Hygiene. 10a. State 10b. County "natural", or items 23a or 28a-f sho gical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore NA 1 ¥ Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4808 Melbourne Road 21229 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 XNo 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. African þ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Specify: American Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) marked other than matic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) 11th Grade Stevenson Construction Labor Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Smith Wendell Vera Day 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4808 Melbourne Road Baltimore, Linda Smith-Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Western Star 20c. Location - City or Town, State Date 1 ★ Burial 2 Cremation 3 Removal from State 01 - 27 - 12Hlicott City, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Wlie Funeral Home P.A. 22. Name and Address of Facility Gilmor Street Baltimore, MD 21217 638 Ν. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph_sician/ ean Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? Yes 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature a 29c. License number (und ddress of person who completed cause of death (Irem 23a) (Type, Print) Charles St. 31. Date filed (Month, Day, State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 25 per me, g924,02/15/2012dhb 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Physician/ Month 1248 PM Vaughn James 2012 OI 29 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore University of Maryland Medical Center 6. Sex If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours Director 421.64.3240 1**XX**M 2 □ F SEPT 13, 1947 Usual Residence of GA 64 show at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director notified 28a-f 1 Yes 3x No GA **FLOYD** ROME 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? must be 23a Funeral 228 RIVER LANE 30165 USA items Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 ☐ Never Married 2 ☐ Married Black, White, etc. o Completed by 1 ☐ Yes 2xx No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", 3 Divorced 4 Divorced Specify: WHITE of Health and Mental Hygiene. item 27 is marked other than "natul other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Lisual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) **ARCHITECT** CONSTRUCTION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ CECIL RUBEN VAUGHN **EDNA HUTTO** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau once. 1 EDGEWOOD DR. LINDALE, GA 30147 **ERIC VAUGHN** 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 XXBurial 2 Cremation XX Removal from State HILLCREST CEMETERY 1.14.2012 LANETT, AL 4 Donation 5 Other (Specify) 21. Signal (w in a g in e Light) e Light ee 22 Name and Address of Easility P.A. t/a MARYLAND MORTUARY SUPPORT GRECORY FNK M01148 426 CRAIN HWY SW GLEN BURNIE, MD 21061 K ter the disease 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Ph_sician/ Empolic Stroke disease or condition Medical resulting in death) Due to (or as a consequence of CERTIFICATION PPROVED BY MEDICAL EXAMINER Examiner Pillectia days 401+16 Sequentially list conditions, Examine ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence on attending physician and I for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day ☐ Pregnant at time of death ☐ Unknown signed by the at Id be detached for g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Preumonia Myoglobinemia Acute Widney Failure 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy perform To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate to the Funeral Director. 2 No 1 🗌 Yes Yes funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 2 **2** NO Other: 1

✓ Inpatient 2

□ ER/Outpatient 3 □ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Ecritifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifie R118064

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Registrar

DHMH 17 Rev 06-2011

University of MD Medical Center 22 S. Greene St. Bultimore MI)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CFNP

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JAN 2 6 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Physici	an/	Registrar	Reg. N	No.	3. Time of Death
Medical Exam	iner	Barbara Williams	Month Da January 13, 2	y Year 2 011 2012	1001 hrs
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Funeral			,	M/DD/YYYY) 9. Birtl Foreigi	
Director		212-88-8245 1 M 2 XF 43 Yrs. Months Days Hours Min.	2-25-	1968 COL	intry) MD
y		Usual Residence of Decedent			
w any		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
Maryland 28a-f show	ţċ	MD Hartord Edge Wood 10e. Street and Number 10f. Zip Code			1 Yes 2 No
or 28s	irec	10e. Street and Number 10f. Zip Code	10g. (Citizen of What Coun	try?
ith the 23a c	aD	860 King Ston Ct. 21040 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Speci	Z Van an Na	USA	
0036 within 72 hours after death with the Maryland jene. nor than "natural", or items 23a or 28s-f sho Medical Examiner must he notified at once.	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married Armed Forces? 11. Never Married 2 Married Married 2 Married Married Married Never		14. Race - Americ White, etc.	an Indian, Black,
fer d		3 Wildowed 4 X Divorced If Yes, Give Year 1 1 Yes 2 X No specify:		Specify: Blace	K
ours a atura	d by	dr. Doodoolie Education (Or Dates:		o. Kind of Business/Ir	
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filed of the court of the	ပ္	17. Father's Name (First, Middle, Last) 18. Mother's Name (Fi			
21215-0036 wild be filed within 7 Mental Hygiene. marked other than	To Be	Frederick E. Underwood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura	L Dav	City or Town State	Zin Code)
○ ₹ 2 ⋅ 3 ⋅ 3 ⋅ 3 ⋅ 3 ⋅ 3 ⋅ 3 ⋅ 3 ⋅ 3 ⋅ 3 ⋅		Lavontae Rhoades-Daugher 418 Grateshead Ct. E.		MO210	
ore, MEss 1 and 2 soft Health and I litem 27	1 1	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, D	ate 20	c. Location - City or	Town, State
Baltimore, permit. Pages 1 a Department of He Important: Wite		1 Burial 2 Cremation 3 Removal from State crematory or other place)	12015 B	ynnoak,	1.40
Baltimo permit. Page Department of Important: injury or oth		4 Donation 5 Other Specify: NOOD LAWN Cunt. 724 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Man	Ch = 14	Fact UNI	E. North Are
Balt permit. Depart Import injury		Bruf. Milhor Baltimore, MD 21202		LUST 1707E	= North lave
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or re failure. List only one cause on each line.		shock, or heart	Approximate Interval
edical miner	V O	Immediate Cause (Final disease a. Occlusive Pulmonary Thromboembolism			Between Onset and Death
		or condition resulting in death) Due to (or as a consequence of):			
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Rec The I	칭		performed		2 No
Vital Rec ysician: The l his certificate l director, page	Be	25. Was case referred to medical 26. Place of Death (Check only examiner? Hospital: Inpution 2 FB/Output 2	one)		
F Vi	၉	1 Yes 2 No 1 inpatient 2 S EXPOURDATION 3 DOA 4 Nursing H		idence 6 Other:	
Division of Vital Records, tal or Attending Physician: The law requir rs after death. al Director: After this certificate has been steed in by the funeral director, page 2 should the fine of the funeral director.	삥	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Natural 28d. Natural 28d. Natural 28d. Natural 28d. Injury at Work? 28d. Injury at Work? 28d. Injury at Work?	d. Describe how i	injury occurred	
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Divipital or ours after Divipital or filled in	Certification:	Suicide 6 Could not be determined (Specify)	or Town, State)		al Route Number, City
Hospi 24 hou Funer ely fil		29a. Certifier (Check only) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due	e to the cause(s)	and manner as state	d
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the			
E % E 8	Me	29b. Signature and title of certifier 29c. License number	290	d. Date signed (Mon	th, Day, Year)
		O.C.M.E.	Ja	nuary 14, 2012	
<i>b</i> .	ı	30. Name and address of person who completed cause of death (Item 23a)		-	
3v		Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 2	1223		
St Regist					
Regist	TGI	HAME O LOIL CHIMA B. HOWEN			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 90 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dolores Jamuary Reuwer Wheeler 22, 20°12 3:30 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 2032 Harman Avenue Baltimore N/ASocial Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 - M 2 - F Months Hours July 10, 10, 1914 215-01-5400 97 Maryland **Director** Usual Residence of Decedent show 10a. State 10b. County with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1XXYes 2 ☐ No MD N/ABaltimore 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral 2032 Harman Avenue 21230 USA permit. Page 1 and 2 should be filed within 72 hours after death \ Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White If Yes, Give Year or Dates 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Rusiness Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Book Keeper Warren Klowas Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charlie Reuwer Oma Mechiny 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HARMON Mol 21730 Denise Hodges-Daughter 2) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Baltimore National
Cemetery 1 Burial 2 Cremation 3 Removal from State Jan.27,2012 Baltimore Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home of Lansdown 21. Signature of Eugeral Service Licenses 2719 Hammonds Ferry Road Lansdowne Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MEI Ptomician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or imjury that initiated events resulting in death) Last the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No be detached for Year Month Day Pregnant at time of death Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Drobely 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an perform 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 ☐ Yes 2 🗶 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Division of Vital Records, P.O. Box 68760 completed filled in by the funeral director,

Medical (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) address of person who completed cause of death (Item 23a) (Type, Print) TON SUN MA 6701 HANVEI State JAN 2 6 2012 Registrar

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

4 Homicide

29a. Certifie

determined

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Williams avenia 01 23 2012 16:40 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death
Baltimore 4c. County of Death 737 Linnard Street 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Days Hours 242-40-9996 Director 1 🗆 M 2 🗶 F 87 03 24 ND Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Baltimore NA MD 1X Yes 2 No ā 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? U . S . A . 21229 Funeral 737 Linnard Street 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 Yes 2 No Specify: "natural", 3 X Widowed 4 Divorced Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Home Housewife 6th grade na 18. Mother's Name (First, Middle, Maiden Surname)
Lillie Fitts 17. Father's Name (First, Middle, Last) should be filed and Mental H Low Gill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
123 South Louden Ave, Baltimore, Md 21229 South Louden Ave, Emmett Gill-Brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite 1X Burial 2 ☐ Cremation 3 ☐ Removal from State ö Maryland National 1/31/2012 Laurel, Md any injury 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part II. Enter the disease, or complications that reused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Due to ras a consequence of): disease or condition Medical resulting in death) Examiner Syears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): Due to (or as a consequence of): resulting in death) Last Physician/Medical 68760 Diaseter Syeurs and IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Box in the past 12 months? g Unknown a 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown Hyperlipidemia 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an Peptic when dispuse Hospital or Attending Physician; The law autopsy 1 ☐ Yes 2 ☐ No Yes 2 N Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 2 No 1 🗌 Yes မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Yes 2 No M 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 24 hours a Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title 29c. License number mo 00066473 1/25/2012 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Natelaine Fripp, mp Ba 14 Son Di ~0 m 1. Date filed (Month, Day, Year) State JAN 2 6 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 Zybe11 Anna 04:08 AM January Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Tate Hospice House Linthicum Anne Arundel Co. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days Hours May 26, 214-24-9881 **Director** 84 <u>Maryland</u> Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD Anne Arundel Co. Brooklyn Park ö 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? with Funeral 5211 Wasena Avenue 21225 United States within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 X Married 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: "natural", Specify: Completed 3 Widowed 4 Divorced White traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Bartender Food & Beverage yrs. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ R. Ridgely India Warfield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) rmit. Page 1 and 2 sh partment of Health a portant: If item 27 is y injury or other tra Mrs. Deborah L. Biron /Daughter 190 Pointe Summit Drive, Greenback, 37742 TNBaltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or otl 20c. Location - City or Town, State Date 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) 01/25/2012 Atlantic Crematory Glen Burnie, MD 21. Signature of Funeral Service Licen-22. Name and Address of Facility Singleton Funeral & Cremation Q -Services PA; 1 2nd Ave SW; Glen Burnie, MD 21061 M01121 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Pnysician/ disease or condition 200 Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence on Cause (Disease or linjury and that initiated events resulting in death) Last burial-trar Due to (or as a consequence of): nding physician use as the burial Physician/Medical death certificate be P.O. Box 68760 IF FEMALE: use s, outcome of pregnancy Live Birth 2 - Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No jo Month Day Year Pregnant at time of death signed by the a d be detached for g Unknow Hospital or Attending Physician; The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe certificate 1 Tes ☐ Yes 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 1 Tes မှ 1 Inpatient 2 ER/Outpatient 3 DOA this Manner of Death Natural 28a. Date of injury (Month, Day, Year) funeral 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 5 \square Pending work? 2 🗌 No Accident Investigation 24 hours after dear Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by Homicide determined Medical 29a. Certifler Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Mayse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

Registrar

State

only one

29b. Signature and title of certifier

305 12 Sel wel 31. Date filed (Month, Day, Yea JAN 2 6 201 32. Registrar's Signature

ne and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JANUARY 20, 2012 ANDREW ZARYK 4:35a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death FOREST HILL HEALTH & REHAB. HARFORD BEL AIR Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Davs Director 214-44-2877 1**XX**M 2 □ F 91 03/17/1920 UKRAINE Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director 28a-f 1 ☐ Yes 2X No MD HARFORD BEL AIR 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be I Funeral 700 N. SHAMROCK ROAD 21014 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 XNo Specify: 3 XWidowed 4 Divorced Specify: WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 MECHANIC SHIPYARD Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ DMYTRO CARYK ANNA HARKOT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANNA SCHAMMEL/DAUGHTER 700 N. SHAMROCK ROAD, BELAIR, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) ST. MICHAEL'S UKR. 1/24/12 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses LTLLY & ZETLER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTIMORE, MD 21231 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ heat Medical resulting in death) Examiner Zaruk, Andrew Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) _ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an puemorna certificate has performed 1 Ves 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 100 ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Hospital or Attending injury Natural 5 Pending 2 Accident
3 Suicide 1 Yes 2 No Investigation 24 hours after deatl Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 20,20,2 032255 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LIS w. Ma-pha. Be 12.11

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (*Month, Day, Year)* **JAN 2 6 2012**

32. Registrar's Sanature

Completed by Funeral Director

Be

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Examiner

Physician/Medical

Medical Certificate: To Be Completed by

	Pleas								All Copies A		gible.	
For		State	of Mary	,					Mental Hygie	ene		
State Registrar					Cer	tificate	of Dear	th	Reg	. No. 🥎	010	2 0 1 0 0 1.
1. Decedent's Name ((First, Middle, L	Last)							2. Date of Death	Day	UTC	3. Time of Death
		earl	Ver	na	E	Armstr	ong		January	23,	2012	8:05 A M
4a. Facility Name (if no	ot institution, g la Mari		nber)				wn, or Loca n oniu n	tion of Death	1		nty of Death	
5. Social Security Num		. Sex	7 Ago (In	yrs. last birtl	hdayl	If Under 1		II nder 24 Hrs.	8. Date of Birth	Da		thplace (State or Foreign
132-30-88. Usual Residence of	38	1 □ M 2 🛚 F	7. Age (iii		Yrs.		Days Hou		June 4, 1		Cot	nplace (state of Foreign untry) 7 Jersey
10a. State 1	10b. County		10	c. City, Town	or Lo	cation						10d. Inside City Limits
Maryland	Harfo	rd		Bel	Ai	r						1 🗆 Yes 2 🕅 No
10e. Street and Numb		rive				10f. Zip Co	ode .015		100	g. Citizen o	S.A.	ountry?
11. Marital Status	Indon D	12. Was Dece	edent Ever	in U.S.	13. V	Vas Decedent	t of Hispanio	c Origin? (Sp	ecify Yes or No-	_		rican Indian.
1 ☐ Never Married 3 🕅 Widowed 4 [Armed Fo d 1 Yes If Yes, Giv Year or Da	2 X No ve		l1	Yes, specify	Cuban, Me	xican, Puerto	Rican, etc.)		lack, White	
	15. Decedent's	s Education		16a.	Deced	lent's Usual C	ccupation		16	b. Kind of		
(Specification (Speci		grade completed) College (1		- 1	(Give I	aind of work a NOT use re	lone during .	most of worl	king			
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17. Father's Name (Fire		,			_		18. N		ne (First, Middle, Mai			
	Stanley	7 E.	,	Wool	ley			Etl	nel E.		Schu	ıry
19a. Informant's Nam	*	,				-			ral Route Number, Ci			Code)
Brenda Mc(⁷ Daugh						ive l	Bel Air, N	Mary 1	and	21015
20a. Method of Dispos 1 X Burial 2 4 Donation 5	Cremation 3	Removal from	State	20b. Place of Whire Memor:	y Ha	sition <i>(Name o</i> Veno ^{r othe} Park	of r place)	1-30				Town, State New York
21. Signature Filmer	ral Service Lice	ensee			22			acility Ru		Fune	eral	Home, Inc. 1204
23a. Part 1. Enter the shock, or heart fi Immediate Cause (Fir disease or condition	failure. List only	y one cause on ea	ach line.	5)							Id Z.	Approximate Interval Between Onset and Death
resulting in death)			(or as a co	nsequence o	f):							
Sequentially list cond if any, leading to immediate. Enter Underlyi Cause (Disease or injure)	ing 🔣	b. Due to ((or as a con	nsequence o	f):							-
that initiated events resulting in death) Las		c. Due to ((or as a cor	nsequence o	f):							
		d								_		
IF FEMALE: 23b. Was decedent pro in the past 12 mo 1 ☐ Yes 2 🛣 N 9 ☐ Unknown	onths?		Birth 2 Inant at tim	Fetal death		Ectopic pred Other (speci					Date of deli Month	ivery Day Year
Part II. Other significa	ant conditions	contributing to de	eath but no	ot resulting in	the ur	nderlying caus	se given in f	Part I.	23e. Did tobac	co use co	ntribute to	the cause of death?
									1 🗆 Yes	2 🗌 No	3 🗌 Pr	robably 4 💢 Unknown
									24a. Was an autopsy performe	d?	prior to death?	topsy findings available completion of cause of
25. Was case referred	to medical	1					O Dia	Donath (OL	1 🗆 Yes 2 🗶	No	1 🗌 Yes	2 🗌 No
examiner?		Hospital:	less 15 - 1	a □ == ::			Other:	Death (Chec		. 17		HACRICE
27. Manner of Death 1 X Natural 2 Accident	5 Pending Investigati 6 Could not	28a. Date (Mont		2 ER/Out 28b. Ti ar) in		28c.	Injury at work?		ome 5 Residenc 28d. Describe how i			fty) HOSPICE

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for it To the Hospital or Attending Physician: The law requires

		1 Yes 2 No 3 Probably 4 X Unknown
		24a. Was an autopsy performed? 1 ☐ Yes 2 ▼ No
25. Was case referred to medical examiner?	26. Place of Death (Check of	nly one)
1 Yes 2 X No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	e 5 Residence 6X Other (Specify) HOSPICE
27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation	(Month, Day, Year) injury work? M 1 ☐ Yes 2 ☐ No	d. Describe how injury occurred
3 Suicide 6 Could not b	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	of Location (Street and Number or Rural Route Number, City or Town, State)
(Check 2 Medical Exami	sician: To the best of my knowledge, death occurred at the time, date and place, and iner: On the basis of examination and/or investigation, in my opinion, death occurred at the se Practitioner: To the best of my knowledge, death occurred at the time, date and place	e time, date and place, and due to the cause(s) and manner stated

29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JUNECIA WHITE, CRNP

No

TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year)

2300 DULANEY VALLEY RD.

31. Date filed (Month, Day, Year) 32. Registrar's Signature

only one) 29b. Signature and title of certifier

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of D 2. Date of Death Physician/ 22 Day 201^{Yea} Maxine L. Anders 11:55 A M January Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Rockville Montgomery National Lutheran Home . Social Security Number If Under 1 Year | If Under 24 Hrs. Funeral 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days 1 🗆 M 2 🔀 F Hours October 7, 1919 219-05-2130 92 Pennsylvania Director Usual Residence of Decedent shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland must be notified at Director 28a-f Rockville Maryland Montgomery 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **23a** Funeral United States 20850 849 Azalea Drive death 1 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Examiner Black, White, etc. 5 1 Never Married 2 Married Yes 2 No Yes, Give Š Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after White 1 ☐ Yes 2 X No Specify. Specify: "natural", Completed 3 X Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. National Institutes Elementary/Seconday (0-12) College (1-4 or 5+) Purchasing Agent 12 of Health Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) id Mental F marked of Esta Viola Rodgers Murray Clayton Davis Department of Health and M Important: If item 27 is man any injury or other traumat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 849 Azalea Drive, Rockville, Maryland 20850 Nancy A. Ward/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other process of Haven Cemetery 20c. Location - City or Town, State natory or other place) 1 🔀 Burial 2 🗌 Cremation 3 🗎 Removal from State January 2012 30, 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland 22. Name and Address of FacilityRobert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850 Signature of Funeral Service Licensee M01498 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause (a.e. a) line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a nonsequence of: and burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last ed by the attending physician detached for use as the buria Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months
1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown To the Hospital or Attending Physician: The law requires that the owithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the To the Funeral Director: After this certificate has been signed Is completed filled in by the funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 1 Yes 2 No Yes 2 Mo 25. W case referred to medica Be 26. Place of Death (Check only one) Other: 2 1 No မ 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury 5 Pending 1 Yes 2 No Accident Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29d Date signed (Month, Day, Year) onuary 23, 2012

State Registrar

DHMH 17 Rev 7/2009

Damascus, Maryland

20872

26033 Ridge RD.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Charles W. Karesh,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Registrar DHMH 17 Rev 06-2011

ORIGINAL

9000

Registrar's Signature

29c. License number

FRANKLIN SQUEEZE

Balto Md 21237

29d, Date signed (Month, Day, Year,

DR

407 AM

2105

BALTIMORE

KANSAS

U.S.A.

Black, White, etc.

WHITE

ROUDEBUSH

MD

Month

9. Birthplace (State or Foreign

10d. Inside City Limits

1 Yes 2 Xo

17349

21237

Approximate Interval Between Onset and Death

Year

Day

1 Yes 2 No

DR Danna

31. Date filed (Month, Da

anna

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Doratota

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** AM ROBERT BRANCH 05:10 JANUARY 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins Bayview Medical Center Baltimore 6. Sex 1 ★M 2 □ F 8. Date of Birth (Month, Day, Year) 10/2/65 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 46 Months Days Hours Min 213-86-7948 MD Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f shov Injury or other traumatic event, the Medical Examiner must be notified at N/ABaltimore MD Director Yes 2 □ No 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 23a or 21206 2114 Tucker Lane - Apt. C2 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

**El Yes 2 No
If Yes, Give 1 986 - 9
Year or Dates: 14. Race - American Indian, African Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 21215-0036 ō 1 ☐ Yes 🗶 No Specify: þ Specify: Amer. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Health Care Elementary/Secondary (0-12) and Mental Hygiene. Is marked other than College (1-4 or 5+) Supervisor 17. Father's Name (First, Middle, Last) Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) Be Robert L. Branch, Jr. Doretta Holmes Elliott 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:3 Department of Health an Important: If item 27 Is any Injury or other trauonce. Rodney Elliott/Brother 2723 Chesterfield Ave, Balt., MD 21206 20b. Place of Disposition (Name of Cemetery, crematory or other place)
Bayview Crematory 1/30/12 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Balt., MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityHari P., Close 578 578 5 PA 21. Signature of Fufferal Service License 23a. Part 1. Inter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) SEPSIS HOUR /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 - Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specity) 2 🗌 No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 No 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other: 4 \sum Nursing Home 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 TYes 2 Accident Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State) To the Funeral 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 JANUARY 23, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CARREIRO-FERNANDA PORTO. 4940 Eastern Avenue, Baltimore, MD, 21224 31. Date filed (Month, Day, Year) State JAN 2 7 2012

DHMH 17 Rev 1/2001 X 11595

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 8:04 PM M <u>Jerome</u> Benda January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 944 Martin Road Essex Baltimore 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 🔀 M 2 🗆 F 6/13/1948 Director Maryland 212-48-4222 63 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🛛 No Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 944 Martin Road 21221 S. A. death v 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. "natural", or 1 XNever Married 2 Married þ 1 ☐ Yes If Yes, Give 2 X No Maryland 21215-0036 72 hours after 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify: Year or Dates White event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 I h and Mental Hygiene. **7 is marked other than "r** Elementary/Seconday (0-12) College (1-4 or 5+) Sheet Metal Mechanic Heating and Air 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Jerome Raymond Anna Mary Kohlepp other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 i 535 Riverside Drive Essex, Maryland 21221 Elaine Perry (Sister) 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 1/27 2012 Gardens of Faith Cemetery Overlea, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex, Maryland 21221 23a. Part 1. Enter the disease, or commications that cadsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of each line. Immediate Cause (Final Myocardial Onset and Death Physician disease or condition Medical resulting in death) Examiner DISCA Se Sequentially list conditions, f any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Exami per tension executed andtran to (or as a consequence of): resulting in death) Last burialphysician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Dav 1 Yes 2 9 Unknown 2 🗆 No the a 9 I Unknown signed by to be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has e 2 page performed? Yes 2 X N 2 🗌 No this certificate 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 **X**No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funera 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Xcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D61907 1 25 12

Registrar
DHMH 17 Rev 7/2009

State

100

Avenue, Bultimore MD 21221

eath (Item 23a) (Type, Print)

Mace

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Willard Gilbert Bayless 25° 2012 8:23 A M January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Stella Maris Hospice Timonium If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Davs (Month, Day, Year) Director 219-10-4144 1 🗙 M 2 🗆 F 88 1923 Julv 18. Maryland Show 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 28a-f 1 Yes 2 XNo Baltimore Bradshaw Maryland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 21087 USA 11815 Reynolds Road 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Yes Give 1 Yes 2 No Specify: Specify: Completed 3 XWidowed 4 Divorced Year or Dates White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Small Machine Mechanic U.S. Government Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Abarilla Myrtle Campbell Edgar Daniel Bayless 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4217 Blakely Ave., Baltimore, MD 21236 mportant; If item 27 Kathy M. Townsley / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 🏿 Cremation 3 ☐ Removal from State Department of Hilltop Service Corp 1-26-2012 4 Donation 5 Other (Specify) Towson, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. Signature of Funeral Service Licensee 1317 Cokesbury Road, Abingdon, Maryland 21009 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician. PANCREATIC CANCER disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause Error Underlying Examiner Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery ☐ Live Birth 2 ☐ Fetat used ☐ Pregnant at time of death Live Birth 2 - Fetal death 3 Ectopic pregna 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 9 2 No 3 Probably 4 Unknown Division of Vital Records, Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician; The law 24 hours after death. autopsy 1 ☐ Yes 2 ☐ No Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 Yes 2 X No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No X Natural 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature ar 29c. License number 29d. Date signed (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. JACKIE JONES, CRNP 31. Date filed (Month, Day, Year) **State** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			4 101	Department of Health and	Mental Hygien	ne
	_			Certificate of Death	Reg. I	No. 2012 01910
	Physicia		1. Decedent's Name (First, Middle, Last)	Booth	2. Date of Death Month	Day Year 3. Time of Death 3. 5 A M
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	- 11	4c. County of Death
-			5. Social Security Number 6. Sex 7. Age fin yrs. last birth	Bathmore (8. Date of Birth	NA
	Funeral Director	٥	212 44-5251	Months Days Hours Min.	(Month, Day, Year	
	nd how at	ř	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location	NOU. 16,14	10d. Inside City Limits
	//anylar //as-fs tiffed	Director		TIMORE		1. Yes 2 □ No
	th the last or 2 as or 2 be no	al Di	10e. Street and Number	10f. Zip Code	10g. (Citizen of What Country?
	ath wil	Funeral	1606 1. BOHD STEET 11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Sp	pecify Yes or No-	14. Race - American Indian,
90	ified within 72 hours after death with the Maryland tall Hygiene. Set of them "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 Married Armed Forces? 1 ☐ Yes 2 No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.
21215-0036	ours a atural' cal Ex	Completed	3 Widowed 4 Divorced If Yes, Give Year or Dates. 15. Decedent's Education 16a.	Decedent's Usual Occupation	140	Specify: Black
215	in 72 h e. nan "n : Medi	lduic	(Specify only highest grade completed) Flementary/Secondary (0-12) College (1-4 or 5±)	(Give kind of work done during most of wor life, DO NOT use retired)	king 16b.	Kind of Business/Industry AREJIAND DEFT OF
	d with dygien ther th	Be Co	17. Father's Name (First, Middle, Last)	ASE WORK	50	actal Services
Maryland	ıld be filed Mental Hy ıarked oth atic event	To E	Edward DIGGS		ne (First, Middle, Maide	en Surname)
lary	1 and 2 should be file if Health and Mental I item 27 is marked o other traumatic eve			Mailing Address (Street and Number or Ru	Route Number, City	or Town, State, Zip Code)
e, N	and 2 Health em 27 ther tr			OGH. BOND ST.		
nor	a. O - L		1 Burial 2 Cremation 3 Removal from State cemeter	Disposition (Name of y, crematory or other place)	, ,	Location - City or Town, State Local bine, Miss
Baltimore,	permit. Page Department Important: I any injury or		21. Signature of Funeral Service Licensee	22. Name and Addres of Facility	EUSPIN TO	CLOMarke fls
<u> </u>	9 2 E 8 8		(m)	2700 Echnones 30	W Ave - 1	BACTO-, MD 2123
	Physician/		23x Part : Enter the disease, or complications that caused the death. Do not stock, or heart failure. List only one cause on each line. Immediate Cause (Final			Approximate Interval Between Onset and Death
	Medical		disease or condition resulting in death) a. All Prose (resulting in death) Due to (or as a consequence of the control of t		ular di	se a se
	Examiner	Ţ.	Sequentially list conditions, b.			
	ted Insit	Examiner	If eny leading to immediate Cause. Enter Underlying Cause. (Disease or injury	1):		
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687	certific nding use as	n/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	- 51		23d. Date of delivery
Вох	law requires that the death certificat has been signed by the attending pt e 2 should be detached for use as the	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☑ No 1 ☐ Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month Day Year
P.O.	at the	, Phy	9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?
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200	aw req as bee 2 sho	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
Å	r The I icate h r, page				performed?	death? No 1 Yes 2 No
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ot	ng Phy ter this meral o	te: To	27. Manner of Death 28a. Date of Injury 28b. Ti	patient 3 - DOA 4 - Nursing H	ome 5 Residence 28d. Describe how inju	
ion	ttendir death. tor: Af	Certificate:	2 Accident Investigation	M 1 ☐ Yes 2 ☐ No		
Division of Vital Records,	al or A s after I Direct		4 Homicide determined 28e. Place of Injury - At home, fan building, etc. (Specify)	m, street, factory, office	28f. Location (Street a City or Town, Star	and Number or Rural Route Number, te)
_	To the Hospital or Attending Physician; The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s	Medical	29a. Certifier (Check Medical Examiner: On the best of my knowledge, d	eath occurred at the time, date and place, a	and due to the cause(s)	and manner as stated,
	o the l	Me	only one) SECERTIFYING Nurse Practitioner: To the best of my know 29b. Signature and title of certifier	ledge, death occurred at the time, date and p	lace, and due to the caus	se(s) and manner as stated. Date signed (Month, Day, Year)
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	Λ./		30. Name and address of person who completed cause of death (Item 23a) (T	PRES 60 ype, Print) 600 N. Wolfe	d	1
	^ງ √ Stat	9	Dansen Marcinis S 31. Date filed (Month, Day, Year) 32. Registrar's Signature	GOUN, WOLFE	st. balkno	2, MP 21287
	Registra		JAN 2 7 2012 Janua J.	pares		

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Examin		4a. Facility Name (if not ins			ber)						of Death			c. County	y of Death		
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition	nation 3 🗌	Removal from	State	C	lace of Disp emetery, cre	matory or c	ther place			Date			•	Town, State	,
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Month William Francis Baker, Jr. 18, 2012 10:55 P^M Medical January 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Rockville Nursing Home Rockville Montgomery Social Security Number If Under 1 Year I If Under 24 Hrs 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign New Jersey 1 X M 2 □ F Months Days Hours Min 158-14-3882 Yrs. Director 86 November 18 Usual Residence of Decedent ate 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 Yes 2 X No Maryland Montgomery Rockville ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a o must be Funeral 4504 Morgal Street 20853 United States iral", or items a Page 1 and 2 should be filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 X Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify "natural" Completed 3 Widowed 4 Divorced Specify: White Year or Dates. 1943-1966 Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) than I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Naval Officer United States Navy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H item 27 is marked ot other traumatic even မ William Francis Baker, Sr. Flora Ashmore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a t: If item 27 is or other trai Nancy Dryden Baker / Wife 4504 Morgal Street, Rockville, Maryland 20853 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Arlington National Cemetery Department of Important: If any injury or once. 2/21/2012 4 Donation 5 Other (Specify) Arlington, Virginia . Signature of Funeral Service Licensee Name and Address of Facilit ert A. Pumphrey Funeral Home, Rockville, West Montgomery Avenue, Rockville, Maryland 20850 Robert 300 West M01619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Failure to Thrive Medical Due to for as a consequence of Examiner Mesothelioma Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) -transit and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical certificate be Bdx 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? Month Year Pregnant at time of death Day 2 No the 9 Unknown 9 Unknown Division of Vital Records, P.O. been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page performed? Yes 2 X No death? Hospital or Attending Physician: The this certificate 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 X No 1 🗌 Yes Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending death. 1 Tyes Accident M Investigation Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 1 A Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) January 20, 2012 D0054566 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Sunitha Bhogavilli, M.D. 9801 Georgia Avenue, Silver Spring, Maryland 20902

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ESTHER BRIKS Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 10 ove etim N/A8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral Months Days Director 073-34-7619 1 🗆 M 2 🕱 F 94 08/28/1917 POLAND Usual Residence of Decedent show at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director must be notified 28a-f 1 Tes 2 X No MD BALTIMORE BALTIMORE ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 2526 FARRINGDON ROAD 21209 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Examiner Black, White, etc. ö 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natura!", 3 X Widowed 4 ☐ Divorced Specify: Year or Dates WHITE injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 12 SEAMSTRESS CLOTHING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည ELIMELECH KAFEL GITTEL UNKNOWN 19a. Informant's Name/Relationship (Type, Print) Department of Health an Important: If item 27 is any injury or attention 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TOBY FADER/DAUGHTER 2526 FARRINGDON ROAD, BALTIMORE, MD 21209 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Briks, 1 X Burial 2 Cremation 3 X Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) ERETZ HACHAM 01/25/12 JERUSALEM, ISRAEL 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ ASPIRATION disease or condition resulting in death) DNEMONIA Medical Due to (or as a consequence of Examiner AL2HEIMERI DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami and resulting in death) Last Due to (or as a consequence of) physician a s the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death the 9 Unknown Unknown signed by t d be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy page, performed?

1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 **X**No Other: မ 1 Nnpatient 2 DER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred eral Director; After filled in by the funer Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide determined City or Town, State) within 24 hours a

To the Funeral C

completely filled Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Sigpat 29c. License number 29d. Date signed (Month, Day, Year) 025039 20/2 erson who completed cause of death (Item 23a) (Type, Print) JU4An JAVOBOUTS 2835 BALTIMORY AVE MA 31. Date filed (Month, Day, Year) 32. Registrar's Signature JAN 2 6 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Elizabeth Carney 10:23P M 2012 January Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 5805 Catoctin Vista Drive Frederick Mt. Airy 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth . Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Day, **Director** 1 □ M 2 🛱 F New York 086-24-1204 79 1932 Mar 17, Usual Residence of Decedent 28a-f show filed within 72 hours after death with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director MD Frederick 1 ☐ Yes 2X No Mt. Airy 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 5805 Catoctin Vista Drive 21771 USA 12, Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ ☐ Yes 2X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify Specify: White 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be fil ment of Health and Mental ant: If item 27 is marked ည Andrew Gdoviak Mary Soloman traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau. once. David Alan Carney/son 5805 Catoctin Vista Dr. Mt. Airy, MD 21771 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Final Journey Crematory 01/27/12 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, MD 21. Signatur of Funeral Service Lice Coing Home Cremation Service P.O. Box 784 MO1251Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Endstage Antiphospholipid Syndrome vears Medical resulting in death) Examiner Antiphospholipid Syndrome 8 years Sequentially list conditions Examiner if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
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5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death the Inknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ۾ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b director, page 2 s autopsy perform 1 Yes 2 No Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital Other: မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 XResidence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury 5 Pending work? eral Director: A filled in by the fi 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

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Medical

29a. Certifier (Check

29b. Signatu

re and title of certifie

31. Date filed (Month, Day, Year)

and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 06-2011

State

Bonita Krempel-Portier, D.O. 121-123 W. Main St. rear Emmitsburg, MD 21727

backs

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

January 25, 2012

29c. License number

H44037

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 25, 2012 5:48 Ам Norris Edward Cooksey Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Brooke Grove Retirement Village Sandy Spring 6. Sex 1 M M 2 □ F Social Security Numbe If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, **Funeral** 8. Date of Birth (Month, Day, Yea Washington, Director 577-28-6564 89 March Usual Residence of Decedent or 28a-f show 10b. County filed within 72 hours after death with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 X No <u>Maryland</u> <u>Prince George's</u> Glenn Dale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10017 Locust Street USA 20769 Was Decedent Ever ... Armed Forces?

1 XI Yes 2 No No If Yes, Give 1942 - Year or Dates 1945 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Completed 3 X Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, the Mediconce. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Catholic University Book Binder Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Eleven Southern Cooksey Emma Ethelyn Norris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 13203 Bermondsey Court Mitchellville, MD 20721 Edward J. Cooksey/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 💢 Burial 2 🗌 Cremation 3 🗍 Removal from State 1/31/2012 Silver Spring, MD 4 Donation 5 Other (Specify) Gate of Heaven 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home -1. Kmi 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between 5 Onset and Death Immediate Cause (Final Ph_sician/ a Glioblastoma disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy Pregnant at time of death Month Year this certificate has been signed by the and director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy Yes 2X No 1 Yes 2 No Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner 1 ☐ Yes 2 🗙 No Other 잍 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State within 24 hours a To the Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title 29c. License number 29d, Date signed (Month, Day, Year) 1)33700 26 January 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOWE MD ETIZAN LAMS PORT 31. Date filed (Month, Day,

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's S

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 11cms 28a-f per me 9924 2-16-12 vt State of Maryland / Department of Health and Mental Hygiene 0 1 2 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ Januar 0215 iam 2012 Medical or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** MOre Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign **Funeral** Hours Min. Septenth, Pro Year 950 Maryland 214-56-3337 61 Director Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits hours after death with the Maryland Director 1 Yes 2 No Carroll Mampstead Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21074 Funeral 4551 Lower Beckleysville Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business Industry within 72 permit. Page 1 and 2 should be filed within 7 Department of Heath and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic excess. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) C.M.S. Policy Analyst Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Adelaide Kittel Alfred Cymer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4551 Lower Beckleysville Rd. Mampstead, MD. 21074 Jean D. Hecker - wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date All Faiths Crematory 1 Burial 2 Cremation 3 Removal from State Manchester, MD. Jan. 27, 2012 4 Donation 5 Other (Specify) 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 21. Signature of Funeral Service Licensee 11605 Reisterstown Rd. Owings Mills, MD. 21117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on eagh line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner CERTIFICATION REPROVED BY MEDICAL EXAMINES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last The law requires that the death certificate be executed the burial-transi Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death the a signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy
performed?
Yes 2 N cate has page 2 s certificate 2 No 1 Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 🗌 No ျှ 1 🌊 Inpatient 2 □ ER/Outpatient 3 □ DOA this 28c. Injury at 114 24 hours after death.

Funeral Director: After the leted filled in by the funeral 27. Manner of Death Certificate: 28a. Date of injury (Month Day, Year) 28d. Describe how injury occurred shot self 28b. Time of **2343** 5 Pending 1
Natural work? 'Inuw 1 Yes 2 X No Linkhown , 14, rod) Accident Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, \$4551 LowerBeckleyville Rd. Hampstead, 4 Homicide determined home at home edical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1912139080 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. GREENT ST BOLLMORYMY 31. Date filed (Month State Registrar

DHMH 17 Rev 7/2009

Box 68760

P.O.

Md

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death January 24, 2012 Physician/ Helen Dolores Chapman 4:28 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Marian Assisted Living Montgomery Brookeville If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 184-18-2188 91 **Director** 1 🗌 M 2 🗓 F Yrs August 21, 1920 | Pennsylvania Usual Residence of Decedent ian "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location Director 1 Yes 2X No Maryland Silver Spring Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 20906 United States 4512 Sigsbee Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status ģ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 72 hours after Specify: White If Yes, Give Year or Dates 1 Yes 2 X No Specify: 3 Wildowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Je filed with. **al Hygiene. *ar than "r Elementary/Secondary (0-12) College (1-4 or 5+) the Homemaker Own Home 2 should be filed with and Mental Hygien 77 is marked other til 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Wessie Mae Weyand Willis Weaver other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is, any injury or other traunonce. 3439 Lindenwood Drive, Laurel, Maryland 20724 Elaine C. Ray/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State January 27, Parklawn Memorial Park 1 \boxtimes Burial 2 \square Cremation 3 \square Removal from State Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2012 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850 Signature of Funeral Service Licensee M01498 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 10 days Immediate Cause (Final Ph_sician/ Multisystem Organ Failure disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cauce. Et of o certific Cause (Disease or injury that initiated events Due to (or as a consequence of) The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IE FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Dementia Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Chronic Renal Insufficiency autopsy performe 1 ☐ Yes 2 ☐ No Yes 2 🛛 No Physician: filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Kr Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA after death. Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred or Attending X Natural 5 Pending 1 Tes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital 24 hours Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature January 24, 2012 D0035045

State Registrar MD 18109 Prince Philip Drive, #200, Olney, Maryland 20832

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Phillip Henjum,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012

		•	1 - State Registrar	C	Certificate of D	eath		Reg. No. 20	112 0	11918
	Physicia	ın/	Decedent's Name (First, Middle, Last)				2. Date of Dea Month	Day	Year	ime of Death
	Medi	cal	Mary Ann 4a. Facility Name (if not institution, give street and number)	Cocker	1y 4b. City, Town, or L	ocation of Death	January	y 23, 20		:00 P M
	Examir	ier	Suburban Hospital			ethesda		10.000	Montgom	erv
茶	Funeral		5. Social Security Number 6. Sex 7. A	Age (In yrs. last birthda		If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day	h , Year)		State or Foreign
14	Director		245-44-6985 Usual Residence of Decedent	80 Yrs	s.		October	2, 1931	North C	arolina
	show dat	호	10a. State 10b. County	10c. City, Town or	r Location					side City Limits
	Mary 28a-f otiffie	Director	Maryland Montgomery			thesda_				Yes 2 X No
	ith the	ral	10e. Street and Number 7908 Greentree Ro	د.	10f. Zip Code	20817		10g. Citizen of		
	eath w	Funeral	11 Marital Status 12. Was Deceden		13. Was Decedent of His If Yes, specify Cuban		ecify Yes or No-		ted Stat	
36	should be filed within 72 hours after death with the Manyland and Mental Hygiene. 'is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 [3 ☐ Widowed 4 ☐ Divorced Year or Dates	XNo	If Yes, specify Cuban 1 ☐ Yes 2 X No		Rican, etc.)	Bla Specify	ck, White, etc. White	
9	hours natura Jical E	Completed	15. Decedent's Education	16a. De	ecedent's Usual Occupat	tion	ula a	16b. Kind of B	Business/Industry	
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auc	be file ental the wed of the wed	70 E	Morgan Morris			16. MOUTE S NAT		Hulme	0)	
ary	hould and M s mar		19a. Informant's Name/Relationship (Type, Print)	19b. N	failing Address (Street ar	nd Number or Rui			State, Zip Code)	
Σ	1 and 2 should be f Health and Men item 27 is marke other traumatic		Thomas B. Cookerly / Husb		08 Greentre	e Road,	Bethesda			
Baltimore, Maryland 21215-0036	o 2 = 5		20a. Method of Disposition 1 □ Burial 2 🎇 Cremation 3 □ Removal from Sta	cemetery.	isposition (Name of crematory or other place	Janu	lary 25,	20c. Location	- City or Town, St	ate
Ħ	permit. Pag Department Important: any injury o		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	Cremat	gomery Orium, Inc				da, Mary	
Ba	Imp Dep any	2	1 month	- M01360	Robert A. Pun 7557 Wisconsi					
			23a. Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each I	ed the death. Do not ine.	enter the mode of dying	, such as cardiac	or respiratory arr	rest,	Interv	oximate val Between
	hysician/		Immediate Cause (Final disease or condition resulting in death)	Acute Myo	cardial Infa	arction			Onse	t and Death
Second Second	Medical Examiner		Due to (or a	as a consequence of):						
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	cuted nd transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.							
_	ificate be executed ag physician and as the burial-transit		resulting in death) Last Due to (or a	as a consequence of):						
8760	ificate h	Medical	d							
89 9	ending use		IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live Birt		3 ☐ Ectopic pregnancy				ate of delivery	
Box	To the Hospital or Attending Physician: The law requires that the death certificate the 24 hours after death certificate has been signed by the attendin completely filled in by the funeral director, page 2, should be detached for use the completely filled in by the funeral director, page 2, should be detached for use the completely filled in by the funeral director, page 2, should be detached for use the completely filled in by the funeral director, page 2, should be detached for use the complete filled in by the funeral director.	Physician/		t at time of death	5 Other (specify)			M	onth Day	Year
J.	that the red by the detail	by P	Part II. Other significant conditions contributing to death	but not resulting in the	he underlying cause give	en în Part I.	23e. Did to	bacco use con	tribute to the caus	se of death?
ds,	quires en sign						1 🗆 '	Yes 2 No	3 Probably	4 🛛 Unknown
S	law req	Completed					24a. Was autop	osy	Were autopsy fine prior to completic	dings available on of cause of
Ř	the cate h						1 🗆 Yes	rmed? 2 X No	death? 1 Yes 2 1	No
lta I	sician s certif directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼No Hospital: 1 ▼ Inc.	atient 2 🗆 ER/Outpa	Other	ce of Death (Chec	ome 5 Resid	longo 6 🗆 Oth	or (Specify)	
_	g Phy er this		27. Manner of Death 28a. Date of in		ne of 28c. Injury	at	28d. Describe h			
0	eath. or: Aff	fica	1 X Natural 5 Pending (Month, L) 2 Accident Investigation 3 Suicide 6 Could not be	ray, roary linja		′es 2 □ No				
Division of Vital Records,	or Atte	Certificate:	4 Deminide determined 28e. Place of I	njury - At home, farm, etc. <i>(Specify)</i>	, street, factory, office		28f. Location (S City or Tow	street and Numb n, State)	oer or Rural Route	Number,
2	ospital hours ineral ly filled	Medical	29a. Certifier 1 X Certifying Physician: To the best							
	the Ho hin 24 the Fu Tpletel	Med	(Check 2 Medical Examiner: On the basis of only one) 3 Continuog Nurse Practitioner: To		dge, death occurred at the	e time, date and p	lace, and due to t	he cause(s) and	manner as stated.	
_	W.		29b. Signature and title of certifie		29c. License			- 1	ed (Month, Day, Ye	ear)
	MA		30. Name and address of person who completed cause of	f death (Item 23a) (Tur		1068405		01	4116.	
D			Jesus David Guevara-Nieto			rgetown	Rd., Bet	hesda, M	faryland	20814
ľ	Sta			strar's						

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	State of Maryland /	Department of He	ealth and Ment	al Hygiene

	1- For State Registrar		Ce	rtificate of	Death			ı	Reg. No.	, , ,	
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year										
	4a. Facility Name (if not institution	on, give street and n	umber)	4	b. City, Town, or	Location of		January_	4c. County (of Death	1843 hrs
	University Hospital	6. Sex	7. Age (In yrs.	last histoday)	Baltimore If Under 1 Yea	n l lf I loods	er 24Hrs.	9 Data of B	irth(MM/DD/YYYY	N O Bid	poloco (Stato or
Funeral Director	5. Social Security Number 123–68–6509	1 M 2 XF	35	Yrs.	Months Day		_		/1976	Foreign	
d any	Usual Residence of Decedent 10a. State 10b. County NY Dutch	ness		, Town or Location							10d. Inside City Limits 1 Yes 2 No
the Maryland or 28s-f show tifted at once.	10e. Street and Number 6 Bilmar Blvd				10f. Zip Code 12569				10g. Citizen of Wh	nat Coun	try?
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f shown other traumatic event, the Medical Examiner must be potified at once. To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 X		cedent Ever in U orces?		Decedent of Hiss, specify Cubar				o- 14. Race White		an Indian, Black,
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hours Fram Exam	 Decedent's Education (Spe Elementary/Secondary (0-12) 		de completed) 1-4 or 5+)		s Usual Occupa st of working life				16b. Kind of Bu	siness/In	dustry
5-0036 ed within 72 hour 19tygiene. other than "natu the Medical Exar Completed	12			Bank T	eller				Bankin	0	
21215-0036 Juld be filed within 7 Mental Hygiene. Marked other than te event, the Medical	17. Father's Name (First, Middle, Paul Misove					Co11	een E	Buchan			
MD 21 d 2 should d 2 should Ith and Me a 27 is ma umatic co	19a. Informant's Name/Relations Scott Case	hip (Type, Print)		6 Bi	lmar Bl	vd Pl			mber, City or Tow Ley,NY		
Baltimore, MD bemit. Pages I and 2 sh Department of Health an Important: If item 27 i injury or other trauma	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Donation 5 Other Specify: 21 Signature of Funeral Service Licensee										
Baltimo permit. Page Department o Important: injury or otl	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Cl 6009 Harford Road Baltimore, Mary 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart										pel. P.A. nd 21214
Physician \(\square\)/Medical	failure. List only one cause	art	Approximate Interval Between Onset and Death								
Examiner	mmediate Cause (Final disease or condition resulting in death) a Narcotics (Morphine) and alcohol Intoxication Due to (or as a consequence of): b.										
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760, ficate be execu g physician and the burial - tra	UNPENDED	23a, pt	3a,27,2. II,27,	8a-f,per 28a-f,pe	r me,g92 er me g9	23 1- 25 3-	31-12 -30-1	sm 2 sm			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transition in the funeral director, page 2 should be detached for use as the burial - transitional Edical Certification: To Be Completed by Physician/Medical Establication:	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ✔ Unit	1 Live b	outcome of preg pirth nant at time of de own	2 Feta	al death 3 er (Specify)	Ectopic	pregnancy	y	23d. Date of Month	delivery Da	ay Year
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To the Host within 24 ho To the Func completely f		nysician: To the bes miner: On the basis and manner s	of examination a								
	29b. Signature and title of certifie				29c. Licens O.C.				29d. Date signe January 12		
80		istant Medical I	Examiner 9	900 W. Baltir	nore Street,	Baltimo	re, MD 2	21223			
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	Physicia Medic	al	Robert L. Cur							Month O I	20	-	Year O/ Z	14.	52 PM
	Examin	er	4a. Facility Name (if not institution, give		7+20		4b. City, Town, o	en Bu				. County		de1	
-	Funeral	13	Baltimore-Washir 5. Social Security Number 6. S		e (In yrs. last b	irthday)	If Under 1 Year	If Under		8. Date of Bir	th	Anne		place (Sta	te or Foreign
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Mar	12 shou lith and 27 is n r traum	- 8	19a. Informant's Name/Relationship (1	Person	nal 19		g Address (Street								
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			23a. Part 1. Enter the disease, or com shock, or heart failure. List only of Immediate Cause (Final												Between nd Death
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Box 6	ath ce attend for us	cian,	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live Birth 4 Pregnant a	2 Fetal dea		Ectopic pregnar Other (specify)	псу			Ī	23d. Dat Mo	te of deliv nth	ery Day	Year
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Division	l or At after Direc	Cer	4 Homicide determined	28e. Place of Injubulding, etc		iarm, stre	et, factory, office			City or To			er or mura	i Houle IV	umber,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier 1 Certifying Phy	sician: To the best of iner: On the basis of e	my knowledge	e, death o	ccurred at the tin	ne, date an	d place, ar	nd due to the d	cause(s)	and manr	ner as sta	ted.	manner etated
	the Hin 24 hin 24 the Fu	Med	only one) 3 Certifying Nur	se Practitioner: To the	e best of my kr	nowledge,	death occurred at	the time, d	late and pla	ace, and due to	the caus	se(s) and n	nanner as	stated.	
	5 Wit		29b. Signature and time of certifier	aro			29c. Licen	se number 427	20		29a. D	ate signed	1		
	ı		30. Name and address of person who		eath (Item 23a	a) (Type, P	rint)				C	110		2012	
_1!) \		Christopherd	0 -	m.13.	370	8 ma	into	c n	Rd	200	ade	na,	mo	21122
4	Sta Registra		31. Date filed (Month, Day, Year)		ar's Signature	-1									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Jan. 2012 Physician/ 5:18 A M Marc Mellon Derrickson Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Montgomery Bethesda 7510 Honesty Way Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours **Director** 1 X M 2 D F 578-80-9170 Washington, DC Dec. 26,1958 53 10d. Inside City Limits or 28a-f show 10c. City, Town or Location 10b. Count filed within 72 hours after death with the Maryland items 23a or 28a-f sho her must be notified at Director 1 Yes 2 X No Bethesda MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 20817 7510 Honesty Way Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11 Marital Status Examiner Black, White, etc. Armed Forces ori 1 ☐ Yes 2 🔀 No If Yes, Give ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 ☐ Widowed 4 🔀 Divorced Completed Year or Dates of Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Computers Marketing Executive Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Carroll Mellon Lloyd Derrickson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Alexandra Derrickson/daughter 7510 Honesty Way Bethesda, MD 20817 Page 1 and 2 Important of Heal.
Important: If item 2.
any injury or other ** 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 1/26/12 Woodbine, MD Signature of Funeral Service License Coing Home Cremation Service P.O. Box Beverly L. Heckrotte, P.A. Clarksville, Box 784 MD 21029 M01251 236. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 14 MOS Immediate Cause (Final Glioblastoma Multiforme Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last the burial-tra Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Other (specify) Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 ☐ Yes 2 🙀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy has performed' 1 Yes 2 No 1 🗌 Yes 2 😾 No 26. Place of Death (Check only one) Be 25. Was case referred to medical Other: 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred 27. Manner of Death Certificate: the Hospital or Attending 1 🔀 Natural 5 Pending 2 🗌 No Funeral Director: A stely filled in by the f Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number D23308 Jan. 25, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Victor M. Priego, M.D. 6420 Rockledge Dr., Suite 4100 Bethesda, MD 20817 Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 22/ 20°12 Pauline J. Dacre Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Towson Manor Care Ruxton if Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 1 M 2 X Country) MD 0291671917 Director 217-09-5187 94 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director notified Parkville MD Baltimore 1 Yes 2 X No . 23a c 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral U.S. 21234 must 3006 Northway Drive and 2 should be filed within 72 hours after death ' Health and Mental Hygiene. em 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Examiner Armed Forces?

1 Yes 2 No 0. by Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 🗆 Yes 2 No If Yes, Give Specify: White Completed 3 X Widowed 4 Divorced A and Mental Hygiene.

27 is marked other than "natural country over the Medical E. Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Sales Retail 9th Grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Angeline Donato Francesco Piccione 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3006 Northway Drive, Parkville, MD 21234 <u> Angela F. Sabo - Daughter</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1:
Department of I
Important: If it
any injury or of cemetery, crematory or other place)
Parkwood Cemetery 1 XBurial 2 Cremation 3 Removal from State 01/25/2012 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Miller-Dippel Funeral Home, Inc., Baltimore, MD 21206 6415 Belair Rd., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Spha seek 5 Medical resulting in death) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Sta burial-trai Due to (or as a consequence resulting in death) Last physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Pes 2 No Month Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? certificate 2 🗀 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 1 🗌 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death. Funeral Director: After this 27. Manner of Death Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes Certificate: 28d. Describe how injury occurred injury 5 Pending 2 \square No Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number. determined 4 Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one the within To the

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title of certifie

was

218,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WIOFO

32. Registrar's Sig

29c. License number

R125808

29d. Date signed (Month, Day, Year)

rules Street, Ste 4105, Butumpir, MD 2124

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 01 9: 25 AM Ellison Vernice Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore, MO Baltimore center Medical Age (Ir **Funeral** Months Min. 1 □ M 2 🗷 **Director** Usual Residence of Decedent or 28a-f show City, Town or Location 10a. State 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director Altimo 1 Yes 2 ☐ No 10e. Street and Num Funeral or items 23a within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian. Armed Forces? Black þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates "natural", Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation (Glive kind of work done during most of working life od NOT use retired) ACNINE OPERAL (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me econday (0-12) Be Baltimore, Method of Disposition 20b 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signatur of Funeral gervice Licen 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Physician/ Denydration disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** MECK alnutrition Sequentially list conditions if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine and I-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): burial attending physician for use as the buria Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Pregnant at time of death 5 Other (specify) been signed by the should be detached Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? this certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 **N**o Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Tyes 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 9 AM 727272 01/23 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301 LISG EIN hor Paul Street Balkmore, MD 21202 St. 31. Date filed (Month, Day, Year, 32. Registrar's Signature

State Registrar

		1	For State	State of Marylan		artment o					2012	0 1	1924
			Registrar 1. Decedent's Name (First, Middle, L	_ast)	Cei	lineate c	Deau	-	2. Date of Dea	Reg. No.	2012	T- V-	of Death
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State of Land	Medic Examin		4a. Facility Name (if not institution, g			4b. City, Tow		on of Death		1	County of Death		
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9	Funeral Director		5. Social Security Number 213-66-0329	5. Sex 7. Age (In yrs. la 1 ☐ M 2 【XF 57		If Under 1 You Months Da	ays Hour	der 24 Hrs. S Min.	8. Date of Birt (Month, Day		9. Birth Cou		e or Foreign
			Usual Residence of Decedent	TEM 2 CAF 37	Yrs.				OCT. 1	195	4 WAS	HINGT	
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	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.	Funeral	11. Marital Status	12. Was Decedent Ever in U.S	S. 13. \	Was Decedent f Yes, specify (of Hispanic	Origin? (Spe	ecify Yes or No-	1-	4. Race - Ameri		
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Maryland	2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "traumatic event, the Med		19a. Informant's Name/Relationship		10, 14, 17	. A -1-1 (Ot				or City or T	own, State, Zip	Cadal 20	747
Ma	2 sho Ith and 27 is r			CHER/SON							IGHTS, M		
ē,	1 and 2 s of Health item 27 i		20a. Method of Disposition	20b. F	Place of Dispo	osition (Name o	f	1	Date		cation - City or		
imo	Page nent c ant: If		1 XBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Sp.	- nemoval ilom State	-	ON NATI		1/24	/2012	SUI	TLAND, M	ARYLA	.ND
Baltimore,	permit. Departr Imports any inji		21. Signature of Funeral Service Lic		22	2. Name and A	ddress of Fa	acility J.	B. JENI		FUNERAL		
ш	<u>~</u> □ = = 0		23a. Part 1. Enter the disease, or c	542							,MARYLA	ND 20 Approxin	
			shock, of heart failure. List on Immediate Cause (Final	ly one cause on each line.	in. Do not ent	er tile mode of	dying, such	as cardiac	or respiratory ar	1031,		Interval E Onset an	3etween
3	Physician Medical		disease or condition resulting in death)	a. SEPSIS Due to (or as a consequ	uence of):								
	Examiner		Company of the Company of the Company	ENCEPHALOPAT									
	_ =	iner	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	uence of):								
_	ecuted and -trans	xan	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a conseq.	uence of):					-			
	be executed sician and burial-transit	dical Examiner	resulting in death) Last	200 10 (0) 40 4 50 100 4									
094	icate g phys	ledi		d									
(687	eath certificate attending phy d for use as th	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live Birth 2 ☐ Feta		☐ Ectopic pred	nancy			2	3d. Date of deli	-	
Box	death he att	Physician/Me	in th <i>e</i> past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	4 Pregnant at time of 9 Unknown	death 5	Other (specif	fy)				Month	Day	Year
P.O.	requires that the des been signed by the s should be detached		Part II. Other significant condition	s contributing to death but not re-	sulting in the I	underlying caus	se given in F	Part I.	23e. Did t	obacco us	se contribute to	the cause c	of death?
S, E	lires the signer of the signer	Completed by							1 □	Yes 2	□No 3□Pr	obably 4	Unknown
Records,	w requ	plete							24a. Was		24b. Were aut	opsy finding	gs available
3ec	he law te has bage 2	mo			-				auto perfo 1 🗌 Yes	ormed?	death?	2 No	// Oddase of
e	hysician: The lav nis certificate has I director, page 2	Be	25. Was case referred to medical examiner?			2		Death (Chec	k only one)				
of Vital	Physic this ce al dire	은	1 ☐ Yes 2 ☑ No 27. Man of Death	Hospital:	ER/Outpatie			Nursing H			Other (Speci	fy)	
n 0	ding Ph h. After th funeral	ate	1 Natural 5 ☐ Pending		injury		Injury at work? 1 \square Yes	2 □ No	28d. Describe	now injury	occurred		
Division	Attendial er death.	Certificate:	2 Accident Investiga 3 Suicide 6 Could no 4 Homicide determin	ot be 28e. Place of Injury - At he							Number or Rui	al Route Nu	ımber,
D	tal or rs afte al Dire			building, etc. (Specif	у)				City or To	wn, State)			
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	Check 2 Medical Ex	Physician: To the best of my know aminer: On the basis of examination	on and/or inves	stigation, in my	opinion, deal	th occurred a	at the time, date:	and place.	and due to the o	ause(s) and	manner stated
	To the within 2 To the Formplet	Me	only one) 3 Certifying I	Nurse Practitioner: To the best of	my knowledge	e, death occurre	d at the time	e, date and p	ace, and due to	the cause(s) and manner a e signed (Month	s stated.	
	¥ ≥ ¥ 8		2				D65915				UARY 22		
1	,		30. Name and address of person w	ho completed cause of death (Iter	n 23a) (Type,		JUJ71.	<i>.</i>		JAIN	CIMI 44	, 201	
11	=			NG M.D. 1500 FOR	REST GI	LEN ROA	D SIL	VER SE	RING, MA	RYLA	ND 2091	0	
	Sta	te	31. Date filed (Month, Day, Year)	2012 32. Registrar's Signa	ature .	arkel							

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 8 per fh g923 1-31-12 vt
State of Maryland / Department of Health and Mental Hygiene 20 | 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Merritt Frederickson, George Jr. 11:00 A M 23. 2012 J<u>anuary</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 8201 Goodhurst Dr. Gaithersburg Montgomery If Under 1 Year If Under 24 Hrs. uate of Birth (Month, Day, Year) 37 ay 25, 1927 7. Age (In yrs. last birthdav) 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** Days New York Months Hours Min. 1 🗓 M 2 🗆 F Yrs 74 Director May 100-28-1879 Usual Residence of Decedent items 23a or 28a-f show ler must be notified at 10a State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director MD 1 Yes 2XXNo Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8201 Goodhurst Dr. 20882 United States within 72 hours after death "natural", or item ledical Examiner n Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 X No Yes, Give 1 ☐ Yes 2 👿 No Specify Specify: White 3 Widowed 4 Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) the Systems Analyst Aerospace Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve 9 Gerorge Merritt Frederickson, Sr. Maude Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy M. Frederickson / Wife 8201 Goodhurst Dr., Gaithersburg, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) All Souls Cemetery 01/27/2012 Germantown, MD 21. Signature of Funeral Service Licensee Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD V 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ACUTE RENAL FAILURE Medical Due to (or as a consequence of) Examiner DEHYDRATION Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) ALZHEIMER'S DEMENTIA burial-transi Cause (Disease or liniury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical that the death certificate be the use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an or Attending Physician: The law autopsy performed? Yes 2 No has page 2 certificate 25. Was case referred to medical director. 26. Place of Death (Check only one) Be examiner? ြို Other: 4 Nursing Home 5 K Residence 6 Other (Specify) 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural
2 Accident
3 Suicide filled in by the funeral 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 \square Pending work? 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A Investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier сопрете Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check To the P within 24 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number

State

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records.

of Vital

Division

Registrar DHMH 17 Rev 7/2009 29b. Signature and title of certifie

Sole

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

JESSE CHAIM SADIKMAN M.D.

D60044

20528 BOLAND FARM RD. #104, GERMANTOWN, MD

29d. Date signed (Month, Day, Year)

JANUARY 24, 2012

20876

			Please	e Type or Pri			Indelible Inlepartment of H			_		egible.	
	_	For State Registrar			ai yiai i		ertificate of D		and w		Reg. No. 2	012	01926
Physicia Medic		1. Decedent's Name Wa1	e (First, Middle, La .ter	David	Fial					2. Date of Dea January		2012	3. Time of Death 8:44 a м
Examin		,	. 0	estreet and number) al Hospital			4b. City, Town, or Prince		of Death eder	ick		unty of Death Calver	
Funeral Director		5. Social Security No. 213–38–64	ımber 6. ∔28		e (In yrs. Ia 7		Months Davs	If Under Hours	Min.	8. Date of Birth (Month Day May 13		9. Birt Mar	hplace (State or Foreign Intry) y Land
yland •f show ed at	ctor	Usual Residence of 10a. State	10b. County		ľ	, Town or							10d. Inside City Limits
the Mar a or 28a- be notifi	al Director	MD 10e. Street and Num	N/A		В	altir	10f. Zip Code					of What Co	y Yes 2 □ No untry?
ath with	Funeral	1929 Wo	odbourn	Avenue 12. Was Decedent E	Ever in U.S	i. I1	21239 3. Was Decedent of Hi		igin? (Spe	cify Yes or No-		S.A.	ican Indian.
s after de ral", or its Examine	þ		ied 2 Married	Armed Forces? 1 K Yes 2 If Yes, Give Year or Dates.	No		If Yes, specify Cuba 1 Yes 2 No	n, Mexica	n, Puerto F	Ričan, etc.) ban		Black, White	
n 72 hour an "natu Medical	Completed	(Spe	15. Decedent's cify only highest g	Education		16a. De	cedent's Usual Occupa ve kind of work done of DO NOT use retired)	ation during mos	st of workir	ng	16b. Kind o	of Business I	ndustry
d withi fygiene ther th nt, the	o l	12			,,,		Banker					anking	
l be file lental F rked of tic ever	To B	17. Father's Name (F Walter	-irst, Middle, Last, \mathbf{F}_ullet	Fial				_	er's Name Armen	(First, Middle, i	Maiden Surr	_{ame)} Santa	maria
permit. Page 1 and 2 should be fled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time Z7 is marked other than "naturaly", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Na	me/Relationship (ailing Address (Street a					m, State, Zip 21093	Code)
Page 1 and ent of Hei nt: If item ry or othe				☐ Removal from State	C	emetery, c	sposition (Name of crematory or other place y Valley	e)	1/26)ate /12		ion - City or	Town, State MD 21093
permit. P Departm Importal any injur		21. Signature of Fur					22. Name and Addres		ity Ruc	k Towso	n Fune	eral H	
hysician/		shock, or hear Immediate Cause (I	t failure. List only Final	nplications that caused one cause on each line	2		enter the mode of dying	g, such as	cardiac o	r respiratory arr	est,		Approximate Interval Between Onset and Death
Medical Examiner		disease or conditio resulting in death)	n f	a. Due to (or as	a consequ	ence of):	ostruch'v	e H	47W	ay a	JJECE	150	
red nsit	Examiner	Sequentially list con if any, leading to im cause. Enter Under Cause (Disease or i	mediate lying linjury	b. Due to (or as a	a consequ	ence of):							
(e) PE : E		that initiated events resulting in death) L		C. Due to (or as	a consequ	ence of):							
micate ng phys	Medi	IF FEMALE:		d									
To the Hospital or Attending Prystolari: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but	Physician/Medical	23b. Was decedent in the past 12 r 1 Yes 2 9 Unknown	months?	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Feta	l death	3	:у			23d. Date of delivery Month Day		
res tnat the signed by d be detac	þ			contributing to death b		_							the cause of death?
e law requi s has been ige 2 shoule	Completed		men							24a. Was a autop	rmed?	prior to death?	copsy findings available completion of cause of
ian; In	Be Co	25. Was case referre	ed to medical				26. Pla	ace of Dea	ath (Check	1 \(\text{Yes} \) only one)	2 🔀 No	1 L Yes	2 No
rhysic this ce al direc	မ		No No	Hospital: 1 Inpati		ER/Outpa 28b. Time	tient 3 DOA Othe	4 <u>□ N</u>		me 5 Resid			f(y)
ath. r: After re funer	icate	1 K Natural 2 Accident	5 Pending Investigation	(Month, Day		injur	y work			28d. Describe h	ow injury oc	curred	
al or Atters as after de al Directo	l Certificate:	3 Suicide 4 Homicide	6 Could not determined				street, factory, office			28f. Location (S City or Tow		ımber or Rur	al Route Number,
ne Hospit in 24 hour he Funera pleted fille	Medical	(Check 2	Medical Exar	ysician: To the best of niner: On the basis of e rse Practioner: To the	xamination	and/or in	vestigation, in my opinic	on, death o	ccurred at	the time, date a	nd place, and	d due to the o	cause(s) and manner stated.
vith con		29b. Signature and	litle of certifier	.c Su	non	6	29c. License	506	653	SunAi	29d. Date si	gned (Month	, Day, Year) 2012
d				completed cause of d	eath (Item		e, Print) GYA	N (G. S.	SunAi	NAD	. 2	0757
Stat Registra		31. Date filed (Month	n, Day, Year)	32 Registra	ar's Signat		CARLOS						
LI 17 Pay 7/20		\2)4	WIN 42 8 TO	1	8	00							

DHMH 17 Rev 7/2009

		For State Registrar	State of Mar		artment of F tificate of L			ene g. No. 20 2	01927	
Physicia	an/	1. Decedent's Name (First, Middle, Last) ANGELINA MARIE GERMAN				2. Date of Death			3. Time of Death 2 12:15P M	
Medi Exami		4a. Facility Name (if not institution, give street and number) GILCHRIST HOSPICE CENTER			4b. City, Town, or Location of Death TOWSON			JANUARY 22, 2012 12:15P M 4c. County of Death BALTIMORE		
			Sex 7. Age (In yrs. last birthday) 1 \(\text{M} \) 2 \(\text{X} \) F 89 Yrs.		If Under 1 Year If Under 24 Hrs. 8. Date of I		8. Date of Birth (Month, Day,) 5 - 2 2 - 1	irth 9. Birthplace (State or Foreign		
3	1	Usual Residence of Decedent		10c, City, Town or Location		10d. Inside City Limits				
Marylan 28a-f sh otified a	recto	MD BALTIMORE		DUNDALK				1 ☐ Yes 2 No		
with the 23a or 2	Funeral Director	10e. Street and Number 7425 SCHOOL LANE		10f. Zip Code 21222			10	10g. Citizen of What Country? U.S.A.		
13-UU-30 72 hours after death with the Maryland n "natural", or items 23a or 28a-f show ledical Examiner must be notified at	2	1. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever Armed Forces? 1 □ Yes 2 □ No. 1f Yes, Give Year or Dates.		If Yes, specify Cuban, Mexican, Puerto Rican			ecify Yes or No- Rican, etc.)	No- 14. Race - American Indian, Black, White, etc. Specify: WHITE		
13-UU36 72 hours after n "natural", o ledical Exam	Completed	15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired)			ing 1	16b. Kind of Business Industry		
ZIZ ZIZ within giene. ner thai		Elementary/Seconday (0-12) College (1-4 or 5+)		life. Do	HOMEMAKER			OWN HOME		
	To Be	17. Father's Name (First, Middle, Last) ORACIO	NOCETA	CETA 18. Mother's Name (First, M			iddle, Maiden Surname) (MANGANO)			
Mar 2 shou th and 7 is m traum	8	19a. Informant's Name/Relationship (Type, Print) GRAND 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PAMELA MCWILLIAMS/DAUGHTER 109 CROYDON ROAD BALTIMORE, MD 21212								
Saltimore, I bernit. Page 1 and 3 Department of Healt mportant: If item 2 any injury or other once.		1 Burial 2 Cremation 3 Removal from State cen			ce of Disposition (Name of Dat metery, crematory or other place) LY HILL MEM. 1-25-			•	LOCATION - City or Town, State	
baltimo permit. Page Department of Important: If any injury or		21. Signature of Funeral Service Licens	/	22	. Name and Addre		CH/ROSE		NERAL HOME 21237	
Ph _{sician/}		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mide of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Which is a second of the complete of t								
Medical Examiner	ner <u>ja</u>	resulting in death)	Co 60 Cimenia				mothes			
ted nsit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	charcumayof):	encyof):				-		
rou cate be executed physician and s the burial-transit	al Exa	that initiated events resulting in death) Last	Due to (or as a co	Due to (or as a consequence of):						
certificate be nding physici use as the bu	Medical	IF FEMALE:	d							
ords, F.O. box 08/ v requires that the death certific been signed by the attending I should be detached for use as	Physician/Me	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1					23d. Date of delivery Month Day Year			
uires that the signed by	è	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown								
DIVISION Of VITAL RECORDS, F.O. BOX To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atter completed filled in by the funeral director, page 2 should be detached for	Completed	24a. Was an autopsy findings availa prior to completion of cause death? 1						completion of cause of		
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ding Ph h. After thi funeral		07 14 (D)								
DIVISION OT its or Attending Plus after death. In Director: After the din by the funeral	Certificate	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Inju building, etc		ry - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number,						
e Hospite 24 hours e Funeral	Medical	29a. Certifier (Check only one) 1 Certifying Physician; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
To th withir To th comp	2	29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) Thurway 23 20								
		30. Name and address of person who completed cause of death (Item 20%) (Type, Print) W. A. P. Ley GBM (6701 N. Charles St., Galts. Mid 216								
Sta Regist		31. Date filed (Month, Day, Year) JAN 2 7 2012	32. Registrar's	Signature fact	les					
		34		-						

DHMH 17 Rev 7/2009

12-00574 Jeremy Grimes Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2012 01928 State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Da 0906 hrs Grimes L. Medical Examiner Jeremy January 22, 2012 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore University Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Linder 1 Year If Linder 24Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Country)Maryland Months Davs Hours Min 25 01/13/1987 Director 213-19-1634 1 M 2 F Vrs Usual Residence of Decedent 10d Inside City Limits 10c, City, Town or Location 10a State 10b. County 1 Yes 2 X No Edgewater MD Anne Arundel 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Director 10g. Citizen of What Country 10e, Street and Number 10f. Zip Code United States 21037 727 Hillmeade Road Funeral 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Armed Forces 1 X Never Married 2 Married Yes White 1 Yes 2 No specify: Specify 3 Widowed Divorced If Yes. Give Year ≦ 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Marine Equipment Operator **Baltimore, MD 21215-0036** 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last Frances L. Grimes Daniel J. Eisel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 727 Hillmeade Rd. Edgewater, Maryland 21037 (mother) Frances Eisel 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Jan Date 26. crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Pages 1 Beltsville, MD. 2012 Chesapeake Crematory 4 Donation 5 Other Specify 22. Name and Address of Facility Rapp Funeral & Cremation Service 21. Signatur of Funeral Service Licensee M00982 933 Gist Ave. Silver Spring, Maryland 20910 Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line Medical Death a Complications of Head Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate Examine cause Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical tending physician a UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy 1 Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown the After this certificate has been signed by the funeral director, page 2 should be detached 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed' ✓ Yes 2 No 1 🗸 Yes 2 No 26.Place of Death (Check only one) or Attending Physician: 25. Was case referred to medical Be Hospital: 1 ✔ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other Nursing Home 5 Residence 6 Other 1 🗸 Yes 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Driver of stationed vehicle hit by another vehicle Jan 17, 2012 0208 hrs 1 Natural 1 Yes 2 ✔ No 5 Pending Director: death. Investigation 2 🗸 Accident in by 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide hours after 6 Could not be or Town, State) RT.50 near Rt. 424, Davidsonville, MD To the Hospital o within 24 hours af To the Funeral D determined (Specify) Major Road / Highway 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number January 23, 2012 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Ana Rubio MD. 31. Date filed (Month, Day Year) 2012 Registrar's Signa State ack

DHMH 17 Rev 1/2001

Registrar

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mont 01 Physician/ 2012 9:10 A Catherine H. Gerstmyer Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner Baltimore** Towson Stella Maris If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday, **Funeral** Hours (Month, Day, Year) Director 1 M 2 XF 218-07-0168 90 04/12/21 Balt., MD ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director MD Baltimore Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S. 21234 4 Joni Court 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 9:10 а.ш. Black White, etc. Yes 2 X No Yes, Give 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 White 1 Yes 2 X No Specify 3 ₩Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Marie Joseph Haubner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1541 Greyfield Trace, Snellville, GA 30078 William A. Gerstmyer - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 😾 Burial 2 □ Cremation 3 □ Removal from State Parkwood Cemetery 01/26/2012 Baltimore, MD Donation 5 Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home 21. Six at re of Funeral Service Licens laga 9705 Belair Rd., Nottingham, MD 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healt failure. List only one cause on each line. Approximate Interval Between Onset and Death Pnysician/ CONGESTIVE HEART FAILURE disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): burial-transit Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months? Live Birth 2 Live Birth Pregnant at time of death Year Month Day the a detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an within 24 hours after death.

To the Funeral Director: After this certificate has performed? Yes 2 X No death? 2 🗌 No the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 **X** Other (Specify) **HOSPICE** 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending Accident Investigation 2 Accident
3 Suicide
4 Homicide filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 X Certifying Nure a Fractition at To the cause (s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 06-2011

2012

JANUARY

CATHERINE GERSTMYER

2300 DULANEY VALLEY RD.

TIMONIUM, MD 21093

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's S

JUNECIA WHITE, CRNP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 201^{Year} January 24, 8:29 P M Timothy Shawn Greer Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct • 18 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🕱 M 2 🗆 F Months Days Hours Pennsylvania **Director** 218-72-7089 956 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland **Funeral Director** 28a-f 1 Yes 2 XNo Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10a, Citizen of What Country? "natural", or items 23a 448 Rose Way USA 21014 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. 21215-0036 1 ☐ Yes 2 X No Specify Specify: 3 - Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Parts Manager Be and bus 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Calvin Greer Sr. Mary Patricia Short any injury or other traumatic Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 Timothy S. Greer Jr 902 Felicia Ct., Bel Air, Maryland 21014 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Air Memorial Gdn | 1-27-2012 Bel Air, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Tage disease or condition resulting in death) acl Medical 110045 **Examiner** Sequentially list conditions Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 5 Other (specify) Month Dav Year Tyes 2 □ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? this certificate has autopsy performed? or Attending Physician: The 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Empatient 2 ER/Outpatient 3 DOA Division of Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 Natural 5 Pending thin 24 hours after death.

the Funeral Director: Af
impleted filled in by the fu 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis or examination and/or investigation, it my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2, To the F complet 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 20053568 chesapaka 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 C

DHMH 17 Rev 7/2009

State

Registrar

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31. Date filed (Month, Day, Year) V

ASON

barker

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Javo М Howard Medical 4a. Facility Name (if not institution, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Annews/ 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month Day, April 1. Sex 1

M 2 □ F 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 13,1933 Days Months Hours Yrs Maryland **Director** <u>214-3</u>0-4178 78 Usual Residence of Decedent 28a-f shov 10a. State with the Maryland items 23a or 28a-f sho ner must be notified at 10b. County 10c. City, Town or Location 10d, Inside City Limits Director 1 🗌 Yes 2 🔀 No <u>Maryland</u> Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 192 Diana Drive 21122 U.S.A. within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, the Medical Examiner Armed Forces? Black, White, etc ö 1 Never Married 2 Married þ Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 Yes 2 No Specify: "natural", Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene.

27 is marked other than 'traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) N/A Sheet Metal Fabricator Westinghouse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Howard Gaigler, Sr. Elsie Matilda Stagge Ι., 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Gloria N. Gaigler (Wife) 192 Diana Drive Pasadena, Maryland 21122 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 M Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cem. 01/28/2012 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22 Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as caudiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ Multisystem Orga CHAPTER TON APPENDIX & MEDICAL CLASHIN disease or condition Medical resulting in death) Due to (or is a consequent of): **Examiner** Securiticity list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) ate has been signed by the atte page 2 should be detached for in the past 12 months? Month 4 ☐ Pregnant at time of death 9 ☐ Unknown Yes 2 No g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>\$</u> Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? After this certificate 2 No 2 2 1 Tes Yes 25. Was cas referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examilier? 1 Yes 12 Other: 2 🗌 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Manth, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1
Natural 5 Pending death. /30 1 Tyes /2011 2 No s after death ☐ Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined City or Town. State) 192 Diane Drive, Pasadena MD 21122 within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examplem On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse ractioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of ce ti 29d. Date signe (Month, Day, Year, 10138 2012

Registrar

State

31. Date filed (Month, Day, Year)

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Print)

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S. Greene

Bultimore MD

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82. Registrar's Signature

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no completed cau

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 6:54P JANUARY 23, 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE SAINT JOSEPH MEDICAL TOWSON CENTER If Under 1 Year If Under 24 Hrs. Hours Min. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) 215-56-7404
Usual Residence of Decedent Days Director 1 🛣 M 2 🗆 F 60 Bloomination. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland **Funeral Director** 28a-f 1 Yes 2 No Monktor putimore 5 10g. Citizen of What Country? pe 23a must Monk items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces Black, White, etc. 'natural", or þ 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: 3 Widowed 4 Divorced Completed Nhit Year or Dates ed other than "natu 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry (Specify only highest grade completed) ife DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) it of Health and Mental H If item 27 is marked of or other traumatic ever 18. Mother's Name (First, Middle, Maiden ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important; If it any injury or o once. 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, anstruncial Chapel-4 Donation 5 Other (Specify) 25 22. Name and Address of Facility 6924 21. Signature of Funeral Service Lice YORK ED, MONKTON, MD ZIIII ICREMATION SERVICES-NOWED 23a. Part 1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. Lis on each tipe.
METASTATIC LUNG CANCER Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** CHORNIC OBSTRUCTIVE PULMONARY DISEASE Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): ALCOHOLISM the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 ası the attending IF FEMALE: be detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Dav Year Pregnant at time of death 1 L Yes 2 L 9 L Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law 24 hours after death.
Funeral Director: After this certificate has autopsy performed? Yes 2 No 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: ၉ 1 Yes 2 No 1 Inpatient 2 KER/Outpatient 3 IDOA Nursing Home 5 Residence 6 Other (Specify completely filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending Accident Investigation 1 Yes 2 No Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 29a. Certifier X certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the F only one) Ceglifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatur 29c. License number D34622

DHMH 17 Rev 06-2011

State Registrar

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empleted cause of death (Item 23a) (Type, Print)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 01933

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21. Signature of Fuence Services 12. Si	e, No. 1 and Health item				20b. Place o	f Disposition	(Name of c						
21. Signature of Fuence Services 12. Si	nor Pages ent of et: H			<u> </u>				em.	01/23	/2012	S	Silver S	Spring, MD
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Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	e exec	ica	X UNPENDED	AMENDED 23a, 2	7,28a-	f,per	me,g9	26 4-2	23–12	sm			
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	760, cate b physic he bur			23c. If yes, outcome of	pregnancy						23d. [Date of delivery	
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	68 certifi nding se as t	ian/		_	-6-4	=		Ectopic	pregnancy	•	M	onth Da	ay Year
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Zabiulian Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223			6111	117	-(O.C.	.M.E.			Janua	ıry 20, 2012	
Zabiulian Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	OR BEAT				,								
State 31. Date filed (Month, Day, Year) Registrar Registrar Registrar	V			12				eet, Baltin	nore, Mi	21223			
WILL MANUEL TO A TO		ate rar	JAN 2 7 2012	2. Registrar's Sig	gnature	asked	•						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 7 Franklin Hayden Jinhary 2012 John Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Glen Burnie Baltimore-Washington Medical Center Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F 78 0876871933 Maryland 216-30-7584 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD Pasadena Anne Arundel 1 Tes 2 No ö 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 107 Magnolia Ave. 21122 United States death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give 55-61 Year or Dates. Maryland 21215-0036 72 hours after 1 ☐ Yes 2XX No Specify. "natural", 3 Widowed 4 Divorced Specify: White Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry. Plastics/Monofilament (Specify only highest grade completed) ulth and Mental Hygiene. 27 is marked other than "r r traumatic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) Plant Plant Manager Be Department of Health and Mental His Important: If Item 27 is marked oth any injury or other traument. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Juanita Schillinger Bernard Hayden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 905 Charisma Ct. Forest Hill, Maryland 21050 Monica Kelly (daughter) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Jan Date25. 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Bethesda, Maryland Uniformed Services Univ. 2012 4 😾 Donation 5 □ Other (Specify) Service Licensee 22. Name and Address of Facility Rapp Funeral & Cremation Service 933 Gist Ave. Silver Spring, Maryland 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause ly Vasi Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): that the death certificate be executed Cause (Disease or linjury as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 D No Month Year Dav Pregnant at time of death 1 ☐ res ∠ L 9 ☐ Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by page 2 should be Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate has Hospital or Attending Physician: The I 24 hours after death.
Funeral Director: After this certificate heted filled in by the funeral director, page perform Yes 2 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: ျပ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural Accident 5 Pending 1 Yes 2 🗌 No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and of certifie 30. Name and address of who completed cause of death (Item 23a) (Type, Print) DWUSH-OF Day, State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #26 PerPHYG923 1/27/2012 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month eons Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Glen Burnie Arundel CrAnne 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) 1 M 2 □ F 218 74 2238 Director 5/26/1959 Maryland Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at by Funeral Director MD 1 Yes 2 X No Anne Arundel Pasadena 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 1271 Pekin Road 21122 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes. Give Completed 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. other than ' Elementary/Secondary (0-12) 12College (1-4 or 5+) Maintenance Supervisor Frontier Town of Health and Mental Hygi item 27 is marked othe other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ George Gerard Holthaus, Sr. Mabel Ash 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1271 Pekin Rd Pasadena, MDBetsy Holthaus - Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or oth cemetery, crematory or other place) 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory |1/11/2012|Baltimore, MD Signature of Femer Pervice Licensee 22. Name and Address of Facility GJ Gonce Funeral Home 169 Riviera Drive Pasadena, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ Cerman antes disease or condition resulting in death) Medical Due to (or as a conseque ce of): **Examiner** 10015 Sequentially list conditions. Examine if any, leading to immediate cause Enter Underlying Cause (Disease or injury Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No ate has bage 2 s 1 Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? 2 Other: 1 Inpatient 2 KR/Outpatient 3 IDOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) al or Attending Ph s after death. Il Director: After th filled in by the funeral 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital of 24 hours at Funeral D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occ urred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State

Registrar

30. Name and addr

31. Date filed (Month, Qay, Year,

27

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MD

-1122

of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ January 23, 201[°]2 7:36 AM Martha Elizabeth Hunt Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Holy Cross Hospital Silver Spring Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Days Hours **Director** 346-68-2817 1 □ M 2 🗓 F 44 February 22, 1967 Minnesota Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits with the Maryland Director or 28a-f sl notified 1 Yes 2 X No Maryland Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code or 10g. Citizen of What Country? s 23a o Funeral 4839 Chevy Chase Blvd 20815 United States items ? Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black White etc. ō ģ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give Specify: White "natural", Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than College (1-4 or 5+) 5+ Elementary/Secondary (0-12) the Psychologist Healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Virginia H. Harris Carl E. Hunt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau once. Carl E. Hunt / Father 4550 North Park Avenue, Chevy Chase, Maryland 20815 January 26 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Montgomery or other place)
Crematorium, Inc. 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2012 Bethesda, Maryland Signatur kai sers Robert A. Pumphrey Funeral Home, Bethesda—Chevy Chase, Inc. M01619 7557 Wisconsin Avenue, Bethesda, Maryland 20814 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a c **Examiner** Securatically list nanditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) and burial-tra Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 as the I IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No jo Month Day Year Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Division of Vital Records, P.O. signed k d be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 WUnknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No မ 1 🗌 Inpatient 2 🗹 ER/Outpatient 3 🗌 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 8c. Injury at 28d. Describe how injury occurred 1 Matural 5 🗌 Pending work? 1 🗌 Yes injury 2 🗌 No 24 hours ofter death, Funeral Director A Accident Investigation completely filled in by the 6 Could not be Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only one)

DV State

Registrar DHMH 17 Rev 06-2011

29b. Signature and title of certifier

Lawrence A.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatur

Ouifiero

29c, License number

M.D. 1500 Forest Glen Road, Silver Spring, Maryland 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Physician/ Miriam E. Hosszu $J_{\text{anuary}}^{\text{Month}}$ 23, 201° 11:24 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 342-30-4163 **Director** 1 □ M 2 🖺 F 74 May 24, 1937 Illinois 28a-f show should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Maryland Rockville 1 X Yes 2 □ No Montgomery ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 5903 St. Lo Avenue 20851 United States 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Bace - American Indian Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc. 0, Black, White, etc. à 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: "natural", If Yes, Give Completed 3 Widowed 4 Divorced Specify. White Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4 or 5+) Mental Hygiene. the Administrative Officer U.S. Government it. Page 1 and 2 should be filed with surment of Health and Mental Hygier ortant: If item 27 is marked other 1 injury or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John E. Ross Miriam Greene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Misty H. Bittinger/Daughter 10312 Lewis Drive, Damascus, Maryland 20a. Method of Disposition permit. Page 1 a
Department of I:
Important: If ite
any injury or ott 20b. Place of Disposition (Name of January 26, 2012 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Montgomery crematory or other place) 4 Donation 5 Other (Specify) Bethesda, Maryland Crematorium, Inc. 21. Signature of Funeral S v e Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Ave., Rockville, Maryland 20850 M00198 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Acute Immediate Cause (Final Physician Sepsis disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Pneumonia Acute Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events Lymphoma Chronic Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Year Day Pregnant at time of death Yes 2 X No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death? autopsy performe Yes 2X No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 🗷 No Hospital Other: မ 1 Nation 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending 2 Accident 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of 29c, License number D53177 January 24, 2012

State

John M. Wallmark, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9707 Medical Center Drive, Rockville, Maryland

20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #30h Per FH G924 2/14/2012 H State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Jon HARLOT 2 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Seasons Hospice Baltimore N/A **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8 Date of Birth 219-26-7776 Months Hours Min Director 1 🗆 M 2 🕱 F 69 03/28/1941 Maryland show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. It is marked other than "natural", or items 23a or 28a-f shour or other traumatic event, the Medical Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits 1 Tes 2 No MD Baltimore Pikesville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 7920 Scott Level Rd. 21208 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify 3 - Widowed 4 - Divorced Specify: Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Elementary/Secondary (0-12)
12th Grade life. DO NOT use retired) Legg Mason Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles Walter Hogan Leeanna Virginia Beaner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie Pennix (niece) Bernice Ave., Baltimore, MD 21229 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20b. Place of Disposition (Name of 2/03/2012 20c. Location - City or Town, State 1 D Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) on-site Crematory: 01/31/12 Baltimore, MD 21. Signature al Service Lic Joseph H. Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD2 MD21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Er ter Or denying Cause Or denying Due to (or as a consequence of) the Hospital or Attending Physician; The law requires that the death certificate be executed bunal-trar that initiated events resulting in death) Last Due to (or as a consequence of): physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months?
1 Yes 2 No 4 Pregnant 9 Unknown Pregnant at time of death Month Day Year 1 Yes 2 9 Unknown ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed i page 2 should be det 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy perform certificate 2 No Yes 2 filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 100 Other: 4 Nursing Home 5 Residence ပ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending work?
1 Yes 2 No 24 hours after death e Funeral Director: / Investigation Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the within 2 only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar
DHMH 17 Rev 06-2011

State

12-00462 Gary A. Hnyla, Jr Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate of Death Reg. No.
Physici Medical Exam		GIRT II HATTEN
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 135 Carroll Road 4c. County of Death Anne Arundel
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Months Days Hours Min. 04 12 1974
ow any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Anne Arunde 1 Pasadena 1
aryland Ba-f shov	Director	MD Anne Arundel Pasadena 10f. Zip Code 10g. Citizen of What Country?
with the Maryland ns 23a or 28a-f sho be notified at once.	al Dire	135 Carroll Road 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-
215-0036 be filed within 72 hours after death with the Maryland nual Hygiene. rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Married 2 Married 2 Married 3 Widowed 4 Divorced of Pates: 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 14. Race - American Indian, Black, White, etc. 15. Yes 2 No specify: White
iours af	ed by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired)
5-0036 led within 72 hou Hygiene. l other than "nat	Completed	College (1-4 or 5+) College (1-4 or 5+) 2 Information Technology US Government
MD 21215-0036 11 should be filed within 7 th and Mental Hygiene. 127 is marked other than	Be Co	17. Father's Name (First, Middle, Last) Gary A. Hnyla, Sr. Mary Florence Dean
2 a de la 2	은	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code)
2 73 9 75 1		Mary Hnyla - Mother 135 Carroll Rd Pasadena, MD 21122 20a. Method of Disposition (Name of cemetery, Date 120c. Location - City or Town, State
nore		1 Burial 2 Toremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: Bayview Crematory 1/23/12 Baltimore, MD
Baltimore, permit. Pages 1 a Department of He Important: If ite		21. Signature of Funeral Service Licensee 22. Name and Address of Facility GJ Gonce Funeral Home, PA
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval
/Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of):
		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.
	Examiner	if any, leading to immediate Due to (or as e consequence of): cause. Enter Underlying Cause (Disease or injury that initiated
uted Id ransit	_	events resulting in death) Last Due to (or as a consequence of): d.
760, icate be executed physician and the burial - transit	Medica	■ UNPENDED
8760, tificate be ng physic as the bur		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year
Box 687 e death certifithe attending	Physician	1 Yes 2 No 9 Unknown
F, P.O. I ires that the signed by the detached	by Ph	Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
ds, Frequires	eted	24a. Was an 24b. Were autopsy findings available
Division of Vital Records, rai or Attending Physician: The law requir is after death. al Director: After this certificate has been sted in by the finneral director, page 2 should the complete of the control of the finneral director, page 2 should the finneral director.	Completed	autopsy performed? performed? 1 ✓ Yes 2 No No No No No No No No
Vital Rec ysician: The his certificate director, page	BeC	25. Was case referred to medical 26.Place of Death (Check only one)
n of Vi ding Physi After this funeral dir	은	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred
ion (teath.	ation	1 Natural 5 Pending Robert Pending Investigation Processing Page 1 Pending Investigation Processing Pending Investigation Processing Pending Investigation Processing Pending
Divis	Certification:	3 Suicide 4 Homicide Suicide 4 Could not be determined Specify) Residence See. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Residence See. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Residence 28f. Location (Street and Number or Rural Route Number, City or Town, State) 135 Carroll Rd. Pasadena, MD.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical C	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.
E \$ E 8	Me	29b. Signature and title of certifier, 29c. License number 29d. Date signed (Month, Day, Year)
		30. Name/and address of person who completed cause of death (Item 23a)
		Melissa Brassell, MD _Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223
St Regist	ate rar	31. Date filed (Morth) Adv. Dary 2012 32. Jegistrar's Signature . January

Bradley Steven Jo	1		State of Maryla	and / D		ent of	Health and			giene			2 0194
Physician Medical Examine	7	1. Decedent's Name (First, Mic BRADLEY	dle,Last) STEVEN		JONE	s			7	2. Date of Dea Month January 2			3. Time of Death 0727 hrs
		4a. Facility Name (if not institu Johns Hopkins Bayv				41	. City, Town, or Baltimore	Location of	Death		4c. County o	f Death	
Funeral Director		5. Social Security Number 212-19-992	6. Sex	7. Age (In	yrs. last birt 24		If Under 1 Year Months Days		24Hrs. Min.	1	-1987	Foreig	
the Maryland a or 28a-f show any tiffed at once.	DILECTO	Usual Residence of Decedent 10a. State 10b. Count MD B 10e. Street and Number 5716 WHITE	ALTIMORE	100	. City, Town		RASPE	BURG			0g. Citizen of Wh	at Cour	•
11215-0036 Id be filed within 72 hours after death with the Maryland fental Hygiene. sarked other than "natural", or items 23a or 23a-f sho event, the Medical Examiner must be notified at once.	Dy ruiteral	—	Married 12. Was De- Armed F 1 Yes Divorced If Yes, Give Yes or Dates: Decify only highest gra	orces? 2 X	No led) 16a.	If Yes	Decedent of His s, specify Cuban es 2 No s Usual Occupati	Mexican, specify: on (Give ki	Puerto R	Rican, etc.)	14. Race White Specify:	etc. WH	can Indian, Black, ITE ndustry
5-0036 ed within 72 hour hygiene. other than "natu the Medical Exau	out biere	Elementary/Secondary (0-12	College (during mos	et of working life.	ER				STF	RUCTION
21215-0036 hould be filed within 7 hould be filed within 7 hould Mental Hygiene. is marked other than tite event, the Medica	Tr. Father's Name (First, Middle, Last) STEVEN JAMES JONES WENDY A. (How a line of the street and Number or Rural Route Number, City or Town, Street And Number or Rural Route Number, City or Town, Street And Number or Rural Route Number, City or Town, Street And Number or Rural Route Number, City or Town, Street And Number or Rural Route Number or Rural R												, Zip Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once		20a. Method of Disposition 1 Burial 2 X Cremative 4 Donation 5 Other 21. Signature of Fundal aervice	on 3 Removal fi		20b. Place of cremate	of Dispositi ory or othe O CR 22. Na	on (Name of cent r place) EMATOR me and Address	Y of Facility	1 – 2 CVA	Date 7 ~ 1 2 CH / ROS	20c. Location CATON SEDALE	City or SVI FUN	Town, State LLE, MD IERAL HOME
Physician Medical Examiner	1	1211 CHESACO AVE ROSEDALE, MD 21237 3a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):											
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tal Records, I cian: The law requires certificate has been signetor, page 2 should be Be Completed		25. Was case referred to medic						of Death (0	Check or	perfor	rmed? de	eath? Ye	·
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Division o Hospital or Attending 24 hours after death Funeral Director: Aftered filled in by the fune all Certification:		2 Accident Inv				rm, street,	factory, office bu		2	unknown 8f. Location (S or Town, S Baltimo	Street and Number state) 5716 W	or Rur hit	ral Route Number, City
DIVI To the Hospital or within 24 hours afte To the Funeral Dir completely filled in		29a, Certifier 1 Certifying Check only 2 Medical Ex	Physician: To the bes aminer: On the basis and manner s	at of my kno of examina	owledge, dea	th occurre	d at the time, dat	death occ	e, and d	ue to the caus	e(s) and manner a and place, and du	e to the	e cause(s)
		29b. Signature and title of certif	ノ、つ	se of death	(Item 23a)		O.C.N		_		January 26,		
State		Ling Li, MD Assist	ant Medical Exa		900 W. B	altimore	Street, Balti	more, M	D 212	23			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death cedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 03,30 PM Januaky 201 Medical Name (if not institution, give street and number) 4h 4c. County of Death City, Town, or Location of Death **Examiner** timone 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Age (In yrs. last birthday) If Under 1 Year 74 (Month, Day Year) 216-34-0980 1937 Director DC 28a-f show 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits or other traumatic event, the Medical Examiner must be notified at Director MD Calvert 1 Yes 2 No Huntingtown ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 20639 3458 Holland Cliffs Road United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Black, White, etc. "natural", or à 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) should be filed within and Mental Hygiene. Attorney Patent Law Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William Drumm Johnston, Jr. Madeline Thomas and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sl tment of Health a tant: If item 27 i Cristina Johnston /Wife 3458 Holland Cliffs Road Huntingtown, MD 20639 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Jan 25 Department of Important: If it 1 Burial 2 Cremation 3 Removal from State Beltsville, Maryland injury o 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 2012 21. Signature of Funeral Service Licensee 22. Nar@reanstrison Famild Funeral Alternatives Ri 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ avitary PS van in Medical resulting in death) Due to (or as a consequence of) Examiner esproton Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Physician/Medical Examine the burial-transi Cause (Disease or injury that initiated events resulting in death) Last Acnte muelopenous Due to (or as a consequence of): attending physician Box 68760 for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Division of Vital Records, 1 🗌 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of completely filled in by the funeral director, page 2 autopsy perform death? 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After injury 5 Pending 1 Yes Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my online, death accurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and title of certifier 29d. Date signed (Month, Day, Year) ny 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wile St Buttimone Many Land Bauh OUN outh Registrar

12-00669 Owen Johnson Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar Certificate of L			J. No.	
Physici edical Exami		Decedent's Name (First, Middle,Last) Owen Landis Johnson		2. Date of Death Month January 24	Day Year	3. Time of Death 1702 hrs
			City, Town, or Location of Deat Annapolis		4c. County of Death Anne Arundel	
Funeral Director		209-36-6667 1xM 2□F 60 Yrs.	If Under 1 Year If Under 24Hr Months Days Hours Mir		(MM/DD/YYYY) 9. Birti Foreigi 5, 1951 Cou	
Maryland 28a-f show any 1 at once.	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Anne Arundel Annapolis				10d. Inside City Limits 1 Yes 2 No
h the Maryla 3a or 28a-f. otified at or	Director		Of. Zip Code	10չ	g. Citizen of What Coun	try?
ter death wit ", or items 2 er must be p	Funeral	1 Never Married 2 Married Armed Forces? If Yes, 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes	Decedent of Hispanic Origin? (S specify Cuban, Mexican, Puerto es 2 X No specify:		14. Race - Americ White, etc. Specify: Wh	ite
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Higgiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	Usual Occupation (Give kind of of working life. DO NOT use ret	tired)	16b. Kind of Business/Ir	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than e event, the Medica	Comp	17. Father's Name (First, Middle, Last)	1	e (First, Middle, Ma	•	
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ore, MD ss 1 and 2 sho of Health and If item 27 is her traumati		20a. Method of Disposition 1 Burial 2 Toremation 3 Removal from State 20b. Place of Disposition crematory or other	place)	Date	20c. Location - City or 1	
Baltimore, permit. Pages I an Department of Hea important: If ites		4 Donation 5 Other Specify: Hilltop Se. 22. Nam	rvice Corp 1-2	Comas Fu		, P.A.
Physician	-	23a. Part i. Enter the disease, or complications that caused the death. Do not enter the realiure. List only one cause on each line.	17 Cokesbury Romode of dying, such as cardiac	·-		land 21009 Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) Atherosclerotic Cardiovascular Disea Due to (or as a consequence of):	se			Death
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Box 687 e death certific the attending p	Physician/	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 1 Live birth 2 Fetal 6 4 Pregnant at time of death 5 Other	death 3 Ectopic pregna (Specify)	ancy	Month Da	ay Year
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Records The law requicate has been page 2 should	Completed			24a. Was an autopsy perform	prior to co ed? death?	opsy findings available mpletion of cause of
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Divisio To the Hospital or Attent within 24 hours after death To the Funeral Director completely filled in by the	Certification	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, f. (Specify)	actory, office building, etc.	28f. Location (Str or Town, Sta	eet and Number or Rura te)	al Route Number, City
Fo the Hos vithin 24 hd Fo the Fun completely	Medical (29a. Certifier (Check only one) 2 ✓ Medical Examiner: On the basis of examination and/or investigation, and manner stated.				
	Σ	29b. Signature and title of certifier	29c. License number O.C.M.E.		29d. Date signed <i>(Mont</i> January 25, 2012	th, Day,Year)
101		30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 900 W. Baltime	ore Street, Baltimore, MI	D 21223		
St Regist	ate rar	31. Date filed (Month, Day, Year) 2012 Registrar's Signature	,			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 01 6:36 2012 James H. Jackson Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Sinai Hospital Baltimore Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days Hours 0372971964 1 🔀 M 2 🗆 F 217-66-2697 47 Maryland Director Usual Residence of Decedent er man "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director MD N/A Yes 2 No Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 5409 Jonquil Ave. 21215 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14 Bace - American Indian. 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by 2 No Yes If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 DWidowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Maryland 2121 life. DO NOT use retired) 10th Grade College (1-4 or 5+) Packer Noxzel Department of Health and Mental Hygies Important: If item 27 is marked other any injury or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Rufus Jackson Sr. Elizabeth Wells 19a. Informant's Name/Relationship (Type, Print) (sister) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4114 Buckingham Rd.,, Baltimore, MD 21207 Lenora Jackson-Chapman Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Baltimore, MD on-site Crematory Joseph Action Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD21217 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events and initiated events.) Examine and -transit To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last physician ar s the burial-t Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death the g 🗌 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No has 1 ☐ Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 🗌 Inpatient 2 🗷 ER/Outpatient 3 🗌 DOA 28a. Date of injury (Month, Day, Year) 27 Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After t completed filled in by the funers Certificate: 1 Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License number 29d Date signed (Month, Dav. Year) rson who completed cause of death (Item 23a) (Type, Print) Commonwea State

DHMH 17 Rev 7/2009

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2012 01944

1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day January 22, 2012 1601 hrs dical Examiner Roger Kyle-Keith 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Johns Hopkins Bayveiw Medical Center Baltimore If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Hours Days Director June 7, 1960 Country) Mary land 1 XM 2 F Yrs 51 214-80-5216 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1 X Yes 2 No Baltimore City Maryland with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21224 726 Conkling Street 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 14. Race - American Indian, Black, Funeral 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 Married hours after death 1X Yes 2 No Specify: White 4 Divorced or Dates: 1 Yes 2 No specify: 3 Widowed 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) be filed within 72 than Baltimore, MD 21215-0036 t. Pages I and 2 should be filed within tment of Health and Mental Hygiene. tant: If item 27 is marked other that or other transmatic event, the Medic. Antiques Small Business Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Margo Hotchkiss Richard Graham Duncan Kyle-Keith 8 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12319 Stafford Lane Bowie, MD 20715 Jill Kyle-Keith/ Sister 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 1 Burial 2 X Cremation 3 Removal from State 1/26/2012 | Glen Burnie, MD 4 Donation 5 Other Specify. Atlantic Crematory 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Şignature of Funerel Service Licensee 16000 Annapolis Road Bowie, MD 20715 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Madacal Death a, Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate <u>a</u> cause. Enter Underlying Cause Exami (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed and cian/Medical AMENDED UNPENDED ed by the attending physician detached for use as the burial -Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery IF FEMALE 23b. Was decedent pregnant in the Year 2 Fetal death 3 Ectopic pregnancy 1 Live birth Month Day past 12 months? Pregnent at time of death 5 Other (Specify) Physic 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>≦</u> 1 Yes 2 No 3 Probably 4 ✔ Unknown 24a, Was an 24b. Were autopsy findings available prior to completion of cause of r this certificate has had director, page 2 sh has performed? death? Yes 2 No 1 🗸 Yes 2 No 26.Place of Death (Check only one) Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical Division of Vital Be Other Nursing Home 5 Residence 6 Other Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 DOA 1 🗸 Yes 2 No After the 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 V Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c, License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier January 24, 2012 O.C.M.E. 30. Name and eddress of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) . Registrar's Signature State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 012 Year Jan 26 7:30A Doreen M. Kabernagel Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll 505 High Acre Dr., Apt Westminster Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours (Month, Day, Year) 213-34-5616 83 1 □ M 2 □**X**F Director 6-1-1928 Canada Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10c. City, Town or Location notified at Director Westminster 28a-f MD Carroll 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n 505 High Acre Dr., Apt 223 21157 USA death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ural", or iten Examiner r Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 No Specify. Specify.white "natural" Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) alth and Mental Hygiene.

27 is marked other thar
or traumatic event, the M Elementary/Secondary (0-12) College (1-4 or 5+) Nursing 12 Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kristin Johnson ည Gudni Sigurdson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) husband 505 High Acre Dr., Apt. 223, Westminster, MD of Health Harry F. Kabernagel 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ō <u>=</u> 9 1 Burial 2X Cremation 3 Removal from State Department of Important: If any injury or once. South Carroll Crem 1-27-12 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fletcher Funeral Home 21. Signature of uneral Service Licenses Honos 254 E. Main St., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner van Sequentially list conditions Examine cause. Enter Underlying
Cause (Disease or Injury Due to lor as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours attendent.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached or use, as the burnal-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No Yes 2 No Be 25. Was case referred to 26. Place of Death (Check only one) examiner? Hospital 2 1 No Other: 1 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 27. Manner Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury work?
1 Yes 2 No 1 atural 5 Pending ☐ Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 06-2011

30. Name and address

completed cause of death (Item 23a) (Type, Print)

trar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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			Registrar 1. Decedent's Name (First, Middle, La	ast)		Cer	lincale	3 OI D	eaui		2. Date of Dea	Reg. No	, _ 0 1	low	3. Time of	Death
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	Examin	er	4a. Facility Name (if not institution, given 3902 Wakefield 1		nber)		4b. City,		Location o	f Death		4c. County of Death Prince George's				
	Funeral		Social Security Number 6.	Sex	7. Age (In yrs. Ia	ast birthday)	If Under Months		If Under 2	24 Hrs. Min.	8. Date of Birt	h	9.	Birthpl	lace (State o	
	Director		184-20-5551 Usual Residence of Decedent	1 □ M 2 💢 F	84	Yrs.	MOTITIES	Days	Hours	IVIIII.	05/29/	1927	Pe	Count	sylvan	ia
	land show d at	tor	10a. State 10b. County		10c. City	y, Town or Loc	cation							10	0d. Inside Cit	ty Limits
	Mary 28a-f	Director		George'	s			Bowie	2						1 🗌 Yes	2 X No
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	s filed within 72 hours after death with the Maryland tral Hygiene. et al. Hygiene worder than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	11. Marital Status		edent Ever in U.S		Vas Deced	lent of His		in? (Spec	cify Yes or No-		14. Race - A	merica	an Indian,	
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	and 2		Anne E. Kress /	Self	20b. P	13902 lace of Dispo			ld Lar		Bowie,		20715 ocation - City	or Toy	vn State	
altimore,	Page 1 nent of ant: If i		1 ☐ Burial 2 【XCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	☐ Removal from cify)	State C	^{emetery, cren} sapeak	natory`or o	ther place			1		Beltsv:		,	
Balt	permit. Page 1 a Department of I Important: If ite any injury or ot once.		21. Signature of Funeral Service Licer	isee		22 R 9	Name an app I	d Address uner	s of Facility al ar	nd Cr Silv	rematio ver Spr	n Se	rvices MD	5 20	910	
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	t the de by the tachec	Physician/M	9 L Unknown	9 🗌 Unkr												
,	Physician: The law requires that the death certifica this certificate has been signed by the attending p al director, page 2 should be detached for use as t	by	Part II. Other significant conditions	contributing to di	eath but not resu	ulting in the u	nderlying o	cause give	en in Part I.				ise contribut			
ord.	requir been should	lete			7 - 1				-		24a. Was a		24b. Were	autop	sy findings a	vailable
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<u> </u>	Physi r this c eral din	o :∈	1 ☐ Yes 2 x No 27. Manner of Death	1 28a. Date	Inpatient 2 of injury	ER/Outpatien 28b. Time of		Other 8c. Injury	4 L Nui		ne 5 🔀 Resid 8d. Describe h			oecify)		
IVISION OF	anding sath. or: Afte	ficat	1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation	on	th, Day, Year)	injury	М	work?	Yes 2 🗌				,			
NVISI	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined	28e. Place	of Injury - At horning, etc. (Specify)		et, factory	, office		2	8f. Location (S City or Tow			Rural I	Route Numb	er,
_	Hospita 24 hours Funeral sted fille	ledical	(Check 2 Medical Exam	ysician: To the b niner: On the bas	is of examination	and/or invest	igation, in r	ny opinior	n, death occ	curred at t	he time, date a	nd place	, and due to t	he caus	se(s) and mar	nner stated.
	To the within 7 To the Comple	>	only one) 3 L Certifying Nu 29b. Signature and title of certifier	rse Practioner:	To the best of my	knowledge, d		red at the License		and place			s) and manner te signed (Mo			
			1 Chun	MO				D5	50343			JA	ANUARY	26	, 2012	2
	151		30. Name and address of person who Kevin Barnabas I					NTER	DR	#201	l, BOWI	E, M	1D 20	716		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 8:50 AM Lula Eureneze Key January 25, 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Manor Care Rossville Baltimore Baltimore Social Security Number 8. Date of Birth (Month, Day, Yea Jun 06, 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Hours 1 M 2 XF 79 Min Year) 1932 251-52-0136 South Carolina **Director** Usual Residence of Decedent or 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1. Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5442 Bucknell Road 21206 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian other traumatic event, the Medical Examiner Armed Force Black, White, etc. þ 1 Never Married 2 Married Yes 2. No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Completed 3 Widowed 4 Divorced Black Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) LPN Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Profit Gadson Rose Fields 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria Vinson /Daughter 5442 Bucknell Road Baltimore, MD 21206 permit. Page 1 and 2 Department of Health Important: If item 2; any injury or other tonce, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Jan 26 1 ☐ Burial 2 🌠 Cremation 3 ☐ Removal from State Beltsville, Maryland 4 Donation 5 Other (Specify) Chesapeake Crematory 2012 Signature of Funeral Service Licenses 22. Name and Address of Facility
Cremation and Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph_sician/ Faultra disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury attending physician and I for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Valve 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? After this certificate 25 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner 1 ☐ Yes 2 ☐ 🗸 6 Other: မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Universing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work' 2 🗆 No filled in by the f Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 31464 MD 1/251

Registrar

DHMH 17 Rev 7/2009

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N. EUTAW ST Shik 366

BALTIMOIZE MD 2120

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DM JMHZ

23d. Date of delivery Day 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 💇 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Mospice 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number To the Hospital or within 24 hours at To the Funeral D than Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and a misosignation, many of the cause (s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2012 25 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 670 N. Charles CHMIES M Dowson MM 31. Date filed (Mo 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

P M

9:55

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Retween Onset and Death

1 🗌 Yes 2 🔀 No

Seoul, Korea

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dav Year Ku-Ju JAN 11:50 AM 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery 11410 Hounds Way Rockvilla Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Yea
July 15. 5. Social Security Number Age (In vrs. last birthday **Funeral** Min 1 ☐ M 2**XX**F Months Hours 87 577-78-0592 China **Director** July Usual Residence of Decedent show dat 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland Director 27 is marked other than "natural", or items 23a or 28a-f si traumatic event, the Medical Examiner must be notified 1 Yes 2 No Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20852 Funeral 11410 Hounds Way United States permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items any injury or other traumatic event the man in items. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11 Marital Status Armed Forces Black, White, etc 1 ☐ Yes 2 🔀 No If Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Asian Specify: Completed 3XXWidowed 4 □ Divorced Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 12 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೭ (not known) (not known) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11410 Hounds Way, Rockville, Maryland 20852 (daughter) Elizabeth Lu 20b. Place of Disposition (Name of cemetery, crematory or other place Jan. Date 28. 20c. Location - City or Town, State 20a. Method of Disposition 1 XI Burial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Memorial Pk. 2012 Rockville, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funery Service Licensee 22. Name and Address of FacilityRapp Funeral & Cremation Service 933 Gist Ave. Silver Spring, Maryland 20910 M00982 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Angrosarcoma Physician/ Cancer disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 22 month Sequentially list conditions, if any, leading to immediate cause. Enter of derlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed To the Funeral Director: After this certificat. has teen signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 4 Pregnant 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 🗌 Yes 2 🗌 No Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🕱 No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: work?
1 Yes 2 No iniury 1 X Natural 5 Pending hours after death. neral Director: Af Investigation Accident 6 Could not be Suicide ☐ Suiciae
☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 124 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie JAN 21,2012 311454

Registrar
DHMH 17 Rev 7/2009

State

11405

Toulone Drive, Potomas, MD 20854

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

27

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Dav Vear 5:15 PM Physician/ Kenneth Eugene Lee 23 J<u>an</u> 2012 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner Essex 704 Pine Branch Place Apt. G <u>Baltimore</u> Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs
Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) 428-84-3467 Director 1 🛛 M 2 🗆 F Sept.8,1943 Mississippi Yrs 68 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland Examiner must be notified at Director 1 Yes 2 XNo Essex MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö 23a 21221 704 Pine Branch Place Apt. G United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No Black, White, etc ò 1 Never Married 2 M Married ş Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: White "natural", 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry I Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Mechanic **Automobile** 3 Years Be 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) should be file and Mental Hris marked ot Mildred Annabelle Shelton ပ္ Ernest Elmo Lee other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is is any injury or all Mrs. Carolyn A. Lee(Wife) G Essex, MD 704 Pine Branch Place Apt. 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place, 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation **/**5 ☐ Other (Specify) 1/28/2012 Baltimore, Maryland Lawn Cemetery 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
Dudalk Marvland 21222 Signature Dundalk. 7922 Wise Ave. omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nly one cause on each line. 23a. Part 1. Enter the dease, shock, or heart failure. Lis Immediate Cause (Final Approximate Interval Retween Physician/ 455-V disease or condition Medical resulting in death) Due to (or as a copsequence of **Examiner** artion Sequentially list conditions, Sequentiary inst corrolators, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examine burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or agra consequence of): E-0-02# attending physician Physician/Medical Box 68760 the **as** IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No ō Year 1 Yes 2 L 9 Unknown the detached Division of Vital Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform has page 2 1 Yes 2 No this certificate filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home _2 X No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) Medical Certificate: To 28c. Injury at work?
1 Yes 2 No 28a. Date of injury (Month, Day, Year) 28b. Time of Manner of Death 28d. Describe how injury occurred Director: After 1 Natural 5 Pending after death. Accident
Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital within 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29a. Certifier

(Check

Signature and title of certific

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15

32

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number D0021

29d. Date signed (Month, Day, Year)

2222

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Ma	ryland / Depa	artment of H tificate of D			21	112	01951
			Registrar 1. Decedent's Name (First, Middle, Last)	Cer	uncate of D	eam	2. Date of Dea	Reg. No. 🚄 🐧 th	1 1 6-	3. Time of Death
	Physicia Medic		Ruth H	lannah Lu	ınd		Month Januar	y 22,	Year 2012	
	Examin		4a. Facility Name (if not institution, give street and number)	_	4b. City, Town, or			4c. County		
تحسد	Funeral		Glen Burnie Health & Rehab 5. Social Security Number 6. Sex 7. Age	Center (In yrs. last birthday)		n Burnie	8. Date of Birtl			nde1 Co.
	Funeral Director		189-07-3466 1 □ M 2XXF 92		Months Days	Hours Min.	(Month, Day	; Year)	Coul	
	d tow	_	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	eation		Nov. 13	,1919	1	10d. Inside City Limits
	larylar 3a-fst iffied	ecto	MD Anne Arundel	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Odenton				1 ☐ Yes 2 ☐ No
	the N a or 28	II Dir	10e. Street and Number		10f. Zip Code	odenton		10g. Citizen of	What Cou	intry?
	th with ms 23 must	Funeral Director	1212 Odenton Road Apt. 10		21113			United		
0	or iter	by Fu	11. Marital Status 1 □ Never Married 2 □ Married 12. Was Decedent Ev Armed Forces? 1 □ Yes 2 ☒ N	lo li	Vas Decedent of His Yes, specify Cubar	, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ce - Ameri ck, White,	can Indian, , etc.
313-0036	ırs afte ural", ıl Exar	ted t	③X☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	1	☐ Yes 2 🕅 No	Specify:		Specify	· W	hite
2	72 hou "natu	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give I	lent's Usual Occupa kind of work done du		ng	16b. Kind of E	lusiness/lr	ndustry
717	vithin jiene. er thar the M		Elementary/Secondary (0-12) College (1-4 or 5+ 11 Years	-)	NOT use retired)			Ret	ail	Sales
yland	filed via Hyg	o Be	17. Father's Name (First, Middle, Last)	<u> </u>		18. Mother's Name		Maiden Surnam	ie)	
Z	d Meni marke matic	으	Morris Montgomery 19a. Informant's Name/Relationship (Type, Print)			Delia	_	O: T	0	0.41
Mai	ge 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	7.0	Mrs. Janice Weaver (Daught		g Address (Street at Box 4608		imore, N			240
ore,	of Hez of Hez if item ir othe		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State	20b. Place of Dispo	sition (Name of natory or other place	e) i	Date	20c. Location	- City or T	Town, State
baitimor	permit. Page 1 a Department of H Important: If ite any injury or ot		4 ☐ Donetion 与 ☐ Other (Specify)	Oak Lawn	Cemetery	1/25/				Maryland
pa	Depar Impo any ir	1	21. Signature of Inferal Service Licensee		Name and Address Ida-Ruck 1922 Wise	Ave. Du	ndalk,	<u>Marylar</u>	k, In	1222
			Part 1. Enter the disease, or complications that caused to shock, or heart failure. List only one cause on each line. Immediate Cause (Final)	the death. Do not ente	r the mode of dying	, such as cardiac o	or respiratory arr	est,		Approximate Interval Between Onset and Death
~	Medical		disease or condition a Respirat	ory Failur consequence of):	:e				-	
	Examiner	_	Sequentially list conditions, b. Pleural	Effusions						-
	ed nsit	dical Examiner	if any, leading to immediate cause. Enter Underlying	consequence or;					-	
	ate be executed physician and the burial-transit	Еха	that initiated events c. Inclastat	ic Colon (ancer					
2	te be (hysicia the bur	dical	d						\rightarrow	
000	ertifica ding pl	(i)	IF FEMALE: 23c. If yes, outcome o	f pregnancy						
200	eath c	Physician/M	in the past 12 months? 1 Ves 2 XNn 1 Pregnant at	Petal death 3	Ectopic pregnancy Other (specify)	/			ate of deliventh	Day Y ear
	t the d by the stacher	Phys	9 Unknown	A A		- i- D-d l				
7.	res tha signed d be de		Part II. Other significant conditions contributing to death bu Atrial fibrillation, Arthri	_		en in Part I.				the cause of death?
ğ	v requi	Completed by	The state of the s	Description	-		24a. Was a		Were auto	opsy findings available
Records,	The lav ate has bage 2)om	Congestive Heart Failure,	rneumonia			autop perfor	med?	death?	ompletion of cause of 2 No
NICAL VICAL	cian: T ertifica ector, I	Be C	25. Was case referred to medical examiner?			ce of Death (Check				
>	Physi this c ral dire	<u>.</u> ۲	1 Hospital: 1 Inpatier 27. Manner of Death 28a. Date of injury	nt 2 ER/Outpatien	t 3 DOA Other	4 🔀 Nursing Ho				(y)
5	nding tth. : After e fune	cate	1 Natural 5 Pending (Month, Day, 2 Accident Investigation	Year) injury	work?		28d. Describe h	ow injury occur	eu	
IVISION	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transic.	Certificate:	3 Suicide 6 Could not be	y - At home, farm, stre (Specify)	eet, factory, office		28f. Location (S City or Tow		er or Rura	al Route Number,
5	spital o		29a. Certifier 1 🛣 Certifying Physician: To the best of m	ny knowledge, death o	occurred at the time,	date and place, a	nd due to the ca	use(s) and man	ner as sta	ited.
	the Ho nin 24 h the Fur thetely	Medical	(Check 2 Medical Examiner: On the basis of exact only one) 3 Certifying Nurse Practitioner: To the	amination and/or invest	igation, in my opinior	n, death occurred at	the time, date a	nd place, and du	ue to the ca	ause(s) and manner stated.
	To To t		29b. Signature and title of certifier Condace Clendle-M	0	29c. License D29			29d. Date signe 1/25/		Day, Year)
			30. Name and address of person who completed cause of dea	ath (Item 23a) (Type, P	rint)					1 01000
			00:114:04	47 York Ro	ad Suite	100 Lu	thervil:	Le, Mar	y Lanc	1 21093
	Stat Registra		31. Date filed (Month, Day, Year) 32. Registrar	a golden						

DHMH 17 Rev 06-2011

The law requires that the death certificate be executed and Division or Vital Records, P.O. Box 68760, the ed by the a Hospital or Attending Physician: funeral director, After this after death. the completely filled in by 24 hours a

or items 23a

'natural",

d 2 should be filed within 7: th and Mental Hygiene. 7 is marked other than "n

Health tem 27 i

1 and 2 should be

72 hours after

Baltimore, Maryland 21215-0036

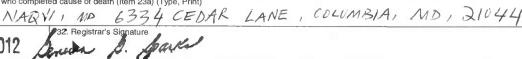
Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0069962 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Medical

31. Date filed (Month, Day, Year) JAN 2 7 2012



within 2. To the I

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 29 Year 2 Month 6900 AM IRVING W LANSMAN Medical Facility Name (if not institution, give street and number **Examiner** 4c. County of Death N/A Funeral Security Number If Unde 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Director 216-18-7102 1 **X**M 2 □ F 89 01/15/1923 MD Usual Residence of Deceden 28a-f show 10a. State is marked other than "natural", or items 23a or 28a-f sho aumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4001 OLD COURT ROAD, #507 21208 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify 3 Widowed 4 Divorced Specify: Completed WHITE Baltimore, Maryland 21215-00 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) OWNER A & L FOODS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 DAVID LANSMAN ANNA GREENBLATT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other traconce, SONYA LANSMAN/WIFE 4001 OLD COURT ROAD, #507, BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) BETH EL MEMORIAL PK 01/26/2012 RANDALLSTOWN, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury as the burial-trar that initiated events resulting in death) Last pue Due to (or as a consequence of): attending physician Physician/Medical P.O. Box 68760 CEELIHOWING BONED BY MEDICAL EXAMINER IF FEMALE use a 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy ρ in the past 12 months?
1 Yes 2 No Month Day Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 🗌 Yes 2

No 3 □ Probably 4 □ Unknown page 2 should been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of this certificate has autopsy perform death? Yes 25. Was case referred to medical examiner?

1 Yes 2 No • Hospital or Attending Physician: 24 hours after death. • Funeral Director: After this certific Be 26. Place of Death (Check only one) Hospital Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury ☐ Natural Accident work? Investigation *∞*000 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined YIOI Home Pikesuil MD 4001 OK Court Medical Certifying Physician: To the best of my knowledge, death occurred at he time, date and place, and due to the cause(s) and manner as stated. 8008 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature and title of 29c. License number မ 29d. Date signed (Month, Day, Year) 25 112 W Belvedere Ave, Baltimore MD 21215 2401

State Registrar . Registrar's Sign

2-00621	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Leg	gible.	
Beverly Wible Moore	State of Maryland / Department of Health and Mental Hygiene	2012	010
1- For State	Certificate of Death	2012	019

		1- For State Registrar		ertificate of	Death		Re	g. No.	12 0193
Physic Medical Exam		Decedent's Name (First, Middle, L Beverly	ast) y Wible Moore	<u>a</u>			2. Date of Deat Month January 22	Day Year	3. Time of Death 1955 hrs
		4a. Facility Name (if not institution,	give street and number)		o. City, Town, or	Location of Deat		4c. County of De	ath
Funeral		Franklin Square Hospita 5. Social Security Number 6.	Sex 7. Age (In yrs.	last hirthday)	Baltimore If Under 1 Yeer	Hilladas 24Us	a la Data at Dia	Baltimore C	•
Director		212-42-0262	M 2 F	68 Yrs.	Months Days			1943 h(MM/DD/YYYY) 9.	eign Baltimore Country) MD
any		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Locatio	n				10d. Inside City Limits
	<u> </u>	MD Balts	imore	Parkv.	ille				1 Yes 2 No
215-0036 be filed within 72 hours after death with the Maryland mal Hygiene. **red other than "natural", or items 23a or 28a-f sho ent, the Medical Examiner must be notified at once.	Director	10e. Street and Number 5 Bourbon Cou			10f. Zip Code	224	10	g. Citizen of What C	•
ith the 123a o	a Di	11. Marital Status	12. Was Decedent Ever in U	15 142 Was	212			United	
death w	Funeral	1 Never Married 2 Marrie			s, specify Cuban,		pecity Yes or No- Rican, etc.)	14. Race - Am White, etc	erican Indian, Black,
after o	by F		ed If Yes, Give Year		res 2 No			Specify: W	hite
2 hours		15. Decedent's Education (Specity Elementary/Secondary (0-12)	only highest grade completed) College (1-4 or 5+)	16a. Decedent's during mos	Usual Occupation of Working life.	on (Give kind of DO NOT use ret	work done ired)	16b. Kind of Busines	s/Industry Grumman
0036 within 72 iene. or than	Completed	12	odiloge (14 di 31)	Admin	istrato	or		NOT GEOP	Gramman
15-0C filed wit Hygien d other		17. Father's Name (First, Middle, La	st)		1		e (First, Middle, M		
MD 21215-0036 12 should be filed within 7 th and Mental Hygiene. 1.27 is marked other than umatic event, the Medica	To Be	Thomas Koch 19a. Informant's Name/Relationship	(Type, Print)	19b. Mailing A	Address (Street		Lockwoo	OCI ber, City or Town, Sta	ate Zin Code)
nore, MD 2121 ages 1 and 2 should be fi nt of Health and Mental it: If item 27 is marked other traumatic event,		Rose Stefan-F	riend	8537	Kings	Ridge	Rd. Ba	ltimore,	MD 21234
ore, I		20a. Method of Disposition 1 Burial 2 X Cremation 3		Place of Disposition		Jan	Date Luary	20c. Location - City	or Town, State Hill, MD
		4 Donation 5 Other Special 21./Signature of Funeral Service Lice	_{fy:} Ch	apel- 1	Bel Air		,2012		
Balti per t. De arm Importe injury e		AN ACTUAL CALL	EN MAN	£ \\ 8 8 (ins Fün 00 Harf	reral cord Ro	hapel a	& Cremat	ion Service D 21234
Physician	1	23 Part I. Enter the disease, or confailure. List only one cause on	nplications that caused the death	. Do not enter the	mode of dying, s	such as cardiac o	or respiratory erre	st, shock, or heart	Approximate Interval Between Onset and
/Medical ≞xaminer		Immediate Cause (Final disease or condition resulting in death)	Multiple Injuries Due to (or as a consequence of	.					Death
		Sequentially list conditions,	o.	n).					
	niner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as e consequence o	ਸੀ):					
ed nsit	Examiner	events resulting in death) Last	Due to (or as a consequence o	of):					
760, icate be executed physician and the burial - transit	Medical	UNPENDED	AMENDED						+
760, icate be physical the buri	-	IF FEMALE:	23c. If yes, outcome of preg	nancy				23d. Date of delive	эгу
Box 687 death certificate at the attending of for use as the	hysician	23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant at time of de	ath =	death 3 (Ectopic pregna	ancy	Month	Day Year
BOy ne death the att	hysi	1 Yes 2 No 9 Unknow	9 Unknown		10.11				
ires that the signed by	Đ P	Part II. Other significant conditions	contributing to death but not re	esulting in the und	lerlying cause giv	ven in Part I.			o the cause of death?
rds, Frequires	Completed						24a. Was ar	24b. Were a	autopsy findings available
of Vital Records, g Physician: The law require then this certificate has been si neral director, page 2 should b	d Ho						autops perforn 1 V Yes 2	ned? death?	
Vital Rec ysician: The his certificate director, page	B S	25. Was case referred to medical examiner?	7.			of Death (Check			2 NO
Physic Physic er this	ျ	1 ✓ Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2 🗸	ER/Outpatient 3				esidence 6 Oth	er:
on C anding arth.	ţ	1 Natural 5 Pending	Jan 22, 2012	1903 hrs			Pedestrian st	ruck by auto	
Division tal or Attendi rs after death. al Director: /	Certification:	2 Accident Investiga 3 Suicide 6 Could no	t be 28e. Place of Injury - At ho	ome, farm, street,	factory, office bu	ilding, etc.	28f. Location (Stror Town, Sta	reet and Number or F	Rural Route Number, City
Divi lospital or hours afte uneral Div		4 Homicide determine	Local offee		eau a so s		Seven Courts D	Drive and Neves C	ourt, Perry Hall, MD
Division of Vital Records, P.O. Box 68: To the Hospital or Attending Physician: The law requires that the death certiff within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as it	Medical	(Check only	clan: To the best of my knowledger: On the basis of examination at and manner stated.	ge, death occurred nd/or investigation	at the time, date i, in my opinion, d	e and place, and death occurred a	due to the cause t the time, date ar	(s) and manner as stand place, and due to	ated. the cause(s)
E % E 8	₩ W	29b. Signature and title of certifier	and marrier stated.	1	29c. License			29d. Date signed (M	
		lalle	UV	5	O.C.M	l.E.		January 23, 201	12
21		 Name and address of person who Zabiullah Ali, M.D. Ass 	completed cause of death (Item istant Medical Examiner		timore Stree	t, Baltimore.	MD 21223		
St	ate	31. Date filed (Month Dev Year)	32. Registrar's Signatu						
Regist	rar	ANIA I COIL	ADVAD TO JEST						1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Jack Richard Mo	cVe	igh, Jr 1- For State Registrar	State of	Marylan		artment o			Mental	Hygiene	Dec No.	20	12 0	195
Physicia Medical Exami		1. Decedent's Name (First		McVei	gh, J	r				2. Date of D Month January	Reg. No. Peath Day 24, 2012	Year	3. Time of 0	
		4a. Fecility Name (if not in Upper Chesapea			oer)		4b. City, To Bel Air		cation of De	eath	4c. 0	ounty of	Death	
Funeral Director		5. Social Security Number 218-52-159	7 6. Sex	2 F	Age (In yrs. I	ast birthday) 61 _{Yr}	Months s.		If Under 24 Hours	_	Birth (MM/DC 7, 195		9. Birthplace (State Foreign New Country)	
nd show any ice.	ır	Usual Residence of Deced 10a. State 10b. Co			10c. City,	Town or Loca	tion e Hal	L	-				10d. Inside	
ith the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number 2941 Brader	nbaugh F	Road			10f. Zip (2116	1		10g. Citizer	of What	Country?	
15-0036 filed within 72 hours after death with the Maryland Hygiene. A other than "natural", or items 23a or 28a-7 she t, the Medical Examiner must be notified at once	by Funeral	11. Marital Status 1 Never Married 2 3 Widowed 4 15. Decedent's Education	Married 1	Dates:	es? 2 X No	lf.	Yes, specify	Cuban, M	exican, Pue	(Specify Yes or erto Rican, etc.)	Sp	14. Race - American Indian, Black, White, etc. White Specify: Kind of Business/Industry		
5-0036 iled within 72 hou Hygiene. d other than "nat the Medical Exa	Completed	Elementary/Secondary (12 17. Father's Name (First, M	0-12)	College (1-4		during n	nost of worki	ng life. DO y Eng	ineer	retired)	John of	Hop Medi	kins Sch	ool
12 Id be fenta	To Be C	Jack Ric 19a. Informant's Name/Rela	chard Mo		Sr	19b. Mailin	g Address	C	onsta	ame (First, Middle Ance Mar or Rural Route N	ie Kot	erwa		
≥ 5 4 5 3 ≥	-	Mary McVeigl 20a. Method of Disposition 1 Burial 2 X Crer			20b. F	lace of Dispos	sition (Name	of cemete	erv.	Date	20c. Loc	ation - Ci	yland 21 ty or Town, State	
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		4 Donation 5 Oth 21. Signature of Funeral Se		1. 1 dr	<u>Cra</u>	rematory or of ins Funer nation S				•			1,Marylan Services nd 21234	
Physician /Medical =xaminer		23a. Part I. Enter the disease failure. List only one of Immediate Cause (Final disor condition resulting in dea	ease a. Puli	ons that cause ne. monary Th to (or as a cor	romboem	bolism	<u>JU Har</u> he mode of	TIORA dying, sud	Road h as cardia	-Parkvil c or respiratory a	Le, Maj	rylar or heart	Approximat Between C	te Interval Inset and
d sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying C. (Disease or injury that initia events resulting in death). It	Due t	ep Venous to (or as a cor	sequence of): 								
execu	dical	UNPENDED	d	IENDED										
ion of Vital Records, P.O. Box 68760, tending Physician: The law requires that the death certificate be teath. for: After this certificate has been signed by the attending physici the funeral director, page 2 should be detached for use as the buri	Physician/Me	F FEMALE: 3b. Was decedent pregnan past 12 months? 1 Yes 2 No 9	23 1 in the 2 1 4 Unknown 9	c. If yes, outc Live birth Pregnant Unknown	ome of pregn	2 Fe	tal death ner (Specify		ctopic preg	nancy	23d. Da Moi	ate of deli	•	Year
s, P.O. Lires that the signed by the detached	2	Part II. Other significant co Status-post right		ributing to dea	ath but not res	sulting in the u	nderlying ca	use given	in Part I.	23e. Did 1 Ye			e to the cause of d	
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the rastler death. Al Director: After this certificate has been signed by the funeral director, page 2 should be detach.	Completed	25. Was case referred to me	dical				26	Place of D	eath (Chao	24a. Was auto perfi 1 • Yes	psy ormed?			
ding Physicia	To Be	examiner? 1 Yes 2 No 27. Manner of Death	Hospit.	al: 1 Inpat		ER/Outpatient 28b. Time of Ir	3 DOA	LOtho	^r 4 Nurs	sing Home 5	Residence		ther:	
VISION or Attendin ufter death. Director: All in by the fur	<u> </u>	2 Accident	Pending Investigation			ne, farm, stree	1	Yes	2 No	28f. Location	(Street and N		Rural Route Num	ber, City
hou hou		Homicide 9a. Certifier 1 Certifyin	g Physician: T	(Specify)	ny knowledge	, death occum	ed at the tim	ne, date ar	nd place, ar	or Town,	se(s) and ma	anner as s	stated.	
To the within To the comple		2 Medical 9b. Signature and title of ce	and r	manner stated	aniination and	uoi nivestigati	29c. Li	cense nun	nber	at the time, date	29d. Date	signed (Month, Day, Year)	
30 V	3	0. Name and address of per Melissa Brassell, N				,		C.M.E.		ore, MD 212	January	y 25, 20) I Z	
Stat Registra					ar's Signature			e oree	i, paitim	OIE, IVID 212				
	_			1		4 10								

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Chizoba Stella	Ма		S	tate of Maryl	land / Dep		Health an	d Ment	al Hy	giene	egible.	001	0	
		1- For State Registrar				ertificate of					Reg. No.	201	2	0 95
Physic Medical Exam	ian nine	1. Decedent's Nar								Date of De Month		Year		of Death
	-	UIIIZUDa	Stella (if not institution	Madubuko on, give street and n	umber)		b. City, Town, or	r Location of	Death	Month January		ounty of Deat		15 hrs
1		12410 Ran			uneal/		Glenn Dale		Duali			ice Georg		
Funera		5. Social Security	Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Yea		24Hrs.	8. Date of B	lirth(MM/DD/	777Y) 9. Bi	rthplace ((State or
Directo		578-25-4	080	1 M 2 X F		40 Yrs.	Months Day	's Hours	Min.		-1971	Forei	gn	Lagos
A]	Usual Residence of			10.00					7 11	17/1	NTS		
ow any			10b. County			y, Town or Location	on							side City Limits Yes 2 No
17215-0036 Id be filed within 72 hours after death with the Maryland Aental Hygiene Aarked other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at once.	uneral Director	MD 10e. Street and Nu	Prince	e Georges	G1	enndale	10f. Zip Code			т		4117		Yes 2 No
he Ma or 28	l ë	12/10 D									10g. Citizen	of What Cou	ntry?	
eath with the litems 23a or	2	12410 Ra	insom D		cedent Ever in U	J.S. 13. Was	20769 Decedent of His	spanic Origin	n? (Spec	ify Yes or N	Nig	eria Race-Amer	ican India	an Black
death r iten	an a	1 Never Marr	ied 2 M	arried Armed F	orces?	If Ye	s, specify Cubar	n, Mexican, F	Puerto Ri	can, etc.)		White, etc.	ican mui	an, black,
after	Ş F	3 Widowed		orced If Yes, Give Yes	ar	1 .	Yes 2 No	specify:			Spe	cify:Afri	can	
hours natur Exam	Pe	15. Decedent's E		cify only highest gra		16a. Decedent's	s Usual Occupat st of working life	tion (Give kir	nd of wor	k done		of Business/		
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5-0036 ed within 7 Tygiene. other than	Completed	17. Father's Name	(First, Middle,	Last)		Unemp1		18 Mother's	Namo /E	iret Middle	Unem Maiden Suri	ployed	l	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be	William M	, ,	,						Esiol		iame)		
D 21215-00; should be filed with and Mental Hygiene 7 is marked other th	일	19a. Informant's Na	ame/Relations	hip (Type, Print)		19b. Mailing /	Address (Stree	t and Number	er or Rur	al Route Nu	mber, City or	r Town, State	, Zip Coo	ie)
MD od 2 sho lith and m 27 is sumati		MMabuese		ge/Sister		1411 P	eartree	Lane						
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ratio of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once		20a. Method of Dis	•	3 Removal fr	20b.	Place of Dispositi	on (Name of cer er place)	netery,	C	ate	20c. Loca	ition - City or	Town, St	ate
Page ment cant:		4 Donation 5				St.Patri	ck Ceme	terv	2-1	5-12	Lag	os Nig	eria	
Baltimore, MI permit. Pages 1 and 2 s Department of Health as Important: If item 277 injury or other traum.		21. Signature of Fu	ral Service	Licens	× W	St.Patri 22. Na								me
	L	23a Part V Enter th	CLU dispasa or	complications that complications	aused the death	300	5 12th	Street	NE	Washi	ngton	DC 20		
Physician /Medical		fallure. List on	ly one cause	on each line.				such as card	diac or re	spiratory an	est, shock, o	or heart		ximate Interval en Onset and
xaminer		Immediate Cause (or condition resulting	Final disease ng in death)	a Acute A	Lcohol consequence o		tion						<u> </u>	Death
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	iner	if any, leading to im cause. Enter Unde	mediate	Due to (or as a	consequence o	f):	**							
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Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate b within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the but	Physician/Me	IF FEMALE: 23b. Was decedent j	pregnant in the		outcome of pregi	_					23d. Da	te of delivery		
K 68	ciar	past 12 months	?	4 Pregna	ותה ant at time of de	ath -	death 3 L	Ectopic pr	regnancy		Mon	th D	ay	Year
BO)	hysi	1 Yes 2 N	lo 9 🗸 Unki	nown 9 Unkno	wn	□ Otne	r (Specify)							
hat the etache	by PI	Part II. Other signif	icant condition	ons contributing to	death but not re	esulting in the und	lerlying cause gi	ven in Part I		23e. Did to	bacco use c	contribute to t	he cause	of death?
S, P.C.										1 Yes	2 No	3 Proba	ably 4	Unknown
ords, w requires to should in	Completed									24a, Was autop	_			ings available of cause of
Recorder The land age 2	E								_		med?	death?		2 No
of Vital Records, ag Physician: The law requir ther this certificate has been soneral director, page 2 should law requires the thin this certificate has been soneral director, page 2 should law requirements.	Bec	25. Was case referre	ed to medical					of Death (Ch	neck only			7 🖳 100		
P Kithis al dire	2	1 Yes 2	2 No		_	ER/Outpatient 3		Other N	ursing Ho	ome 5	Residence	6 Other:	Scene	
n of ding P After funera		27. Manner of Death 1 Natural			of Injury Day,Year)	28b. Time of Inju	· _ · ·		- 1		now injury oc			
Division tal or Attendii rs after death. al Director: A	Certification:	2 X Accident		igation Id I-	-6-12	fd 8:24	TOM	s 2 X No	al	<u>cohol</u>		med ex		
Divi	틛	3 Suicide	6 Could detern	HOLDO	Resid	me, farm, street, f	actory, office bu	ilding, etc.	28f.	Location (S or Town, S	tate) 1241	Mer or Rura 0 Ran	al Route SOM	Number, City
Tospit 4 hour		4 Homicide 29a. Certifier		(Opcomy)							le,Md.			
Divisior To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the 1	Medical	(Check only one) 2	Medical Exam	rsician: To the best iner:On the basis of	f examination an	ie, death occurred id/or investigation	at the time, date, in my opinion,	e and place, death occurr	and due red at the	to the cause time, date a	e(s) and mar and place, ar	nner as stated nd due to the	d. cause(s)	
F ≥ F ⊗	Æ	29b. Signature and		and manner sta	ated.		29c. License					signed (Mont		
		All	1. h	m/////////////////////////////////////	W)		O.C.M	.E.			January		,,,	
	}	30. Name and addre	ss of person w	no completed cause	of death (Item :	23a)	J	-			L			
		Melissa Bras	sell, MD	Assistant Med	•	,	Baltimore Str	eet, Balti	more,	MD 2122	3			
		31. Date filed (Month	Day Year)	119 37 Reg	istrar's Signatur	e L	,							
Regist		JA	NAIL	UIL Kener	m B.	parke								
DHMH 17 Rev 1/20 OCMF 2006	01	OGM	in in			ORIGINAL								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Mc Bride Day 4 2012 Physician/ 1046 AM ames January Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Hospital Baltimore 9. Birthplace (State or Foreign Date of Birth **Funeral** (Month, Day, Year) 1 XM 2 □ F **Director** 10 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location notified at Director Baltimore MD 1 X Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ō must be by Funeral items 23a Vincent Lane Apt. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc annes McBride 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 14 ack Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry K.E. Michel Elementary/Secondary (0-12) College (1-4 or 5+) Deliven 12th avade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Kichburg McBride, Jr. Jernesna James 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Carter Durius Mills, MD 2117 4105 Silher Oaks Thil (Daulanter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Timorium, MD 01/30/2012 4 Donation 5 Other (Specify) Dulaney Vaughn C. Greene Funeral Services 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 8728 Liberty Road Randallstum MD 21133 e disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the shock, or heart Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of Exami burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician thed for use as the buria Certificate: To Be Completed by Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy signed by the atter d be detached for u in the past 12 months? Month Day 4 Pregnant a
9 Unknown Pregnant at time of death 2 No Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Division of Vital Records, 1 Yes sompletely filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 Yes 2 No • Hospital or Attending Physician: 24 hours after death.
• Funeral Director: After this certifical 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No 1 Yes Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred 1 Natural 5 Pending 2 🗌 No Investigation Accident Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 3 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 24,2012 In W. Ch January D41129 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2435 West Belvedere Assenne Baltonine W. Cho, M.D. 31. Date filed (Man 2. Registrar's Signa

State Registrar

	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legil	ole.
25	State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2	12 01958
Physician/	1. Degedent's Name (First, Middle, Last) Connell Sr. Date of Death Month And Date of Death	3. Time of Death 2:50 A M
Medical Examiner		
Funeral Director	5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 1 f Under 1 Year If Under 24 Hrs. Months Days Hours Min. (Month, Day, Year) 1 2 A 2 1 - 19(-7)	9. Birthplace (State or Foreign Country)
faryland sa-f show tified at ector		10d. Inside City Limits 1 1 Yes 2 1 No
death with the Maryland ritems 23a or 28a-1 sho ner must be notified at Funeral Director	10e. Street and Number 2229 Walshire Avenue 21214 US	at Country?
ther dee	1 Never Married 2 Married 1 Yes 2 No	American Indian, White, etc.
S Hair T	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give find of work done during most of working life DP NOT use retired) Wroen-ter	ness/Industry
0 2 2 1 0	17 Father's Name (First, Middle, Last), 18, Moher's Name (First, Middle, Margen Syrname)	
≥ ≤ € 5 €	She ia L. Niller (Sister) 2229 Walshire Ave. Batto.	10 21214
5 9 9 9 9 9 9 9 9 9 9	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of demethy, crematory or other place) Around State Around Stat	ity or Town, State
Baltim permit. Pac Departmen Important: any injury	21. Signature of Funeral Tervice Lisense 2 being and April 25 (Facility 2014 1) 15 (Co. 1)	URVICES
Physician/	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailure. List only one cause on each line. Immediate Cause (Final	Approximate Interval Between Onset and Death
Medical Examiner	disease or condition resulting in death) a. Due to (or as a consequence of):	rigina
scuted and transit xaminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Course (Disease or injury that initiated events)	
e e e e	resulting in death) Last Due to (or as a consequence of):	
Records, P.O. Box 68760 The law requires that the death certificate be execate has been signed by the attending physician in page 2 should be detached for use as the burial Completed by Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	· ·
S, P.O. Ires that the signed by the deed detach	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.	ute to the cause of death?
Division of Vital Records, tal or Attending Physician: The law requires is after death. In Director: After this certificate has been signed in by the funeral director, page 2 should be Certificate: To Be Completed by	24a. Was an autopsy pric performed? det	re autopsy findings available or to completion of cause of ath?
fital R sician: The sician: The certificate lirector, pe	25. Was case referred to medical examiner?	Yes 2 No
Division of Vital Recc To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2. Medical Certificate: To Be Comp	i i i i i patierit. 2 i i 2 i Ottipatierit. 3 i i DOA 4 i i i i i i i i i i i i i i i i i i	Specify)
Division all or Atte safter de Il Directo ed in by the Il Certif		or Rural Route Number,
Division of To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer Medical Certificate.	29a. Certifier (Check only one) 3 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner (Check only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner (Check only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner (Check only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner (Check only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner (Check only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner (Check only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner (Check only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner (Check only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner (Check only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner (Check only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) a	the cause(s) and manner stated.
To the with To the come	29b. Signature and title of certifier MD 29c. License number D31464 127	
N	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHOA113 A. HASHMI MD, 621 N. EVTAW ST SHIE 308 BALTIMORA	= MD 21201
State Registrar	31. Date filed (Month, Day, Year) 32. Registrar's Signature	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Aaron McCoy, Jr	State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No. 2012	0195
Physician/ Medical Examine	1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time	e of Death
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death University Hospital 4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYYY 9. Birth lace (In yrs, last birthday)	,
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. In.	ary qua
	Ba Himare	Yes 2 No
r death with the Maryland or items 23s or 23s-f show must be notified at once. Funeral Director	10e, Street and Number 4047 Cedardale Rd. 10f. Zip Code 21215 10g. Citizen of What Country? USA	
ufter death with 11", or items 23 oct must be no y Funeral		an, Black,
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Inst. If item 27 is marked other than "natural", or items 23s or 23s-fash or other transmatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	of Dates:	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other tranmatic event, the Medical To Be Comple	Alaron McCoy Sr. Sandra Tillman	
and 2 should and 2 should fealth and Me trem 27 is ma transmatic er	Kim Tilman - aunt 40°47 Cedardale Rd. Baltimory Mar 20a. Method of Disposition 20b. Place of Disposition (Name of cernetery, Date 20c. Location - City or Town, Si	yland
Baltimore, ME permit. Pages I and 2 s Department of Health at Important: If item 27 injary or other transm	1 Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address o Facility Contact Co	aryland
Balt Bernit Depart Injury		eximate Interval
/Medical Examiner	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	een Onset and Death
ted 1 Insit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	
cuted and transit	(Ussasse of injury that initiated events resulting in death) Last Due to (or as a consequence of): d.	
60, ate be executed hysician and e bunal - transit		
box 6876 the death certificate the death certificate by the attending phy ched for use as the! Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, detectine of pregnant y 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	Year
p, P.O. Baires that the de signed by the I be detached for the by the by the by the by the by	1 Yes 2 No. 3 Probably 4	
cords aw requestas been 2 should	24a. Was an autopsy find prior to completion death? 1 ✓ Yes 2 No 1 ✓ Yes	
Vital Recystian: The label bis certificate la director, page	25. Was case referred to medical 26. Place of Death (Check only one)	
ion of Virenting Physicar. After this the funeral distribution: To	TW TES 2 NO	
Division of To the Hospital or Attending, within 24 hours after death. To the Funeral Director: Afte completely filled in by the funer ledical Certification:	2 V Accident Investigation 3 Suicide 6 Could not be determined (Specify) Local Street (Spec	
To the Hos within 24 h To the Fur completely		s)
F 3 F 3	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, V O.C.M.E. January 25, 2012	Year)
v	30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
State Registrar	g 31. Date filed (Month, Day Year) 22. Registrar's Signature	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 24, Month 21:34 PM **Physician** STELLA JANUAR 2012 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Johns Hopkins Bayview Medical Center **Baltimore** Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F Virginia Director 216-34-3879 Usual Residence of Decedent 10a. State 10d, Inside City Limits 10c. City, Town or Location Dunda1k 1 ☐ Yes 2 ☐ XNo Director Baltimore MD 28a-f 10g. Citizen of What Country? 10e, Street and Number 10f. Zip-Code ō pe United States 23a 21222 7854 St. Bridget Lane Funeral must Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ★No If Yes, Give Year or Dates: ò 1 ☐ Yes 2 录No Specify. Specify: þ 3√ Widowed 4 Divorced White "natural" Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Health and Mental Hygiene. Elementary/Secondary (0-12) Clerical <u>Office Manager</u> 12 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be 1 nent of Health and Mental 1 Jessie Castle William Moore ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7854 St. Bridget Lane Dundalk, Maryland 21222 Terry C. Miller (Daughter) permit. Pages 1 and Department of Heali Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 😿 Burial 2 □ Cremation 3 □ Removal from State Holly Hill Mem. Gdns. 1/26/2012 Middle River, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
Dundalk Marvland 21222 21. Signature of Funeral Service Licensee 7922 Wise Ave. Dundalk, Maryland 23 art 1. Enter the José se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fail re. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Respiratory tailure **Physician** 10 minutes disease or condition /Medical resulting in death) Due to (or as a consequence of) **Examiner** Week ntevstitia Dheumonia Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) death certificate be executed that initiated events resulting in death) Last the burial-tra Due to (or as a consequence of) Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Month Vear in the past 12 months? Day Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 TYes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 Yes 2 🗌 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other: 1 ☐ Yes 2 ☐ No 4 \square Nursing Home 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) ၉ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending investigation s after death. 1 Tes 2 🗌 No 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 24 hor To the Fune completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 24,2012 2ES 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Grazion M.D. 4940 Eastern Avenue, Baltimore, MD, 21224 32. Registrar's Signature State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

Box 68760,

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year -oulg January 2017 Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Manor Care Ruxton Baltimore 6. Sex 7. Age (In yrs, last birthday) If Under If Under 24 Hrs. 1 Year 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 212-26-3820 84 **Director** 1 □ M 2 🛛 F Vrs 1927 Maryland May 14, Usual Residence of Decede 28a-f show 10a. State Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits by Funeral Director 1 ¥ Yes 2 □ No MD Baltimore 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural". or items 29a 21214 **USA** 3126 Weaver Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Completed 3 X Widowed 4 ☐ Divorced white event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Harry Dokelis Mercina Koulouris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 534 Hampton Lane; Towson, MD 21286 Evelyn M. Ambridge / daughter 20a. Method of Dispo 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Cremation 3
Removal from State injury 4 Donation 5 Other (Specify) Demetrios Cem. 1/27/2012 Cub Hill, MD 21. Signature of Fi 22. Name and Address of Facility 1050 York Road Towson, MD 21204 Ruck Towson Funeral Home, Inc. 23a, Part 1. Enter the disease, or complions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only o Immediate Cause (Final Onset and Death Physician/ emention disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or injury the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 for use as IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 X No Month Day Year Pregnant at time of death 5 Other (specify) detached 1 ☐ Yes 2 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔏 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has, page 2 performed 2 No Yes 2 X No 1 🗌 Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 X No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 🕅 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) 28a. Date of injury (Month, Day, Year) filled in by the funeral 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? iniury 1 X Natural 5 Pending 2 No 1 Yes Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical within 24 hou

To the Funer

completely file 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 06-2011

State

the

0

(Check

only one)

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Bellona Lane #216

29d. Date signed (Month, Day, Year)

10WSON

MD

2/200

January

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #12 Per FH G924 2/01/2012 JH State of Maryland / Department of Health and Mental Hygiene

			for State Registrar	State of Mary		epartment of r Certificate of D				0.1060		
			Decedent's Name (First, Middle, Last)				7	2. Date of Death		3. Hime of Death		
4.30	Physicia Medic		Robe	rt Jar	mes	Mitchell		Ja ^{Month} ary	25°, 201°2°	10:40 PM		
	Examin	er	4a. Facility Name (if not institution, give si				Location of Death		4c. County of Deat	1		
· · ·	Francis I		12916 Dulaney Val 5. Social Security Number 6, Sex				en Arm I If Under 24 Hrs.	8. Date of Birth	Baltin	nore thplace (State or Foreign		
	Funeral Director				81	Months Days	Hours Min.	(Month, Day,	Year) Co	untry)		
	, mo		Usual Residence of Decedent					Feb. 12,	1930 Ma	aryland		
	ryland I-f shu ied at	ctor	10a. State 10b. County		c. City, Town or					10d. Inside City Limits		
	ne Ma or 28a notif	Dire	Maryland Baltimo	re	GLe	n Arm 10f. Zip Code		1	0g. Citizen of What Co	1 Ves 2 No		
	with th	eral	12916 Dulaney Va	llow Pood			057	"	U.S.A.	only !		
	leath items er mu	Funeral Director		12. Was Decedent Ever	in U.S.	3. Was Decedent of Hi If Yes, specify Cuba		ecify Yes or No-	14. Race - Ame			
36	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at		1 Never Married 2 X Married	Armed Forces? 1XXYes 2X No If Yes, Give		1 ☐ Yes 2 🕅 No		nican, etc.)	Black, White Specify:			
21215-0036	ours a atura cal Ex	Completed by	3 Widowed 4 Divorced 15. Decedent's Edu	Year or Dates.	160 Dr	ecedent's Usual Occup				√hite		
215	n 72 h an "n Medi	mpl	(Specify only highest grad Elementary/Secondary (0-12)		(G	ive kind of work done of the control		ing	16b. Kind of Business	Industry		
21	withii giene ner th t, the	o) e	Elementary/decondary (0-12)	2	Prod	uctivity C	onsultant	t	Consulti	ng Ind.		
Maryland	e filed ntal Hy ed oth event	To Be	17. Father's Name (First, Middle, Last)	т - 1	M = 1 - 1-	-11	18. Mother's Nam	e (First, Middle, M	aiden Surname) Brooks			
ž	should be file and Mental 7 is marked of raumatic eve		Robert 19a. Informant's Name/Relationship (Typ)	John	Mitch			Leona				
Ma	12 shouth and the sho	111		Wife		ailing Address (Street a 16 Dulaney			en Arm, MD			
re,	1 and 2 s of Health item 27		20a. Method of Disposition	12	20b. Place of Di	sposition (Name of crematory or other place		- 1	20c. Location - City or			
imo	Page 1 ment of ant: If it ury or o		1 ☐ Burial 2 🔯 Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State		Service Co	rp. 1-27	7-2012		Maryland		
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Si vature of Furieral Service Licensee	_		22. Name and Addres		ck Towsor owson, Ma	n Funeral l ervland 2	Nome, Inc. 1204		
			23a. Part 1. Enter the disease, or complishock, or heart failure. List only one		death. Do not					Approximate		
are -	Physician/	1 77	Immediate Cause (Final disease or condition	LING		ICER				Interval Between Onset and Death		
	Medical Examiner		resulting in death)	Due to (or as a co		, , ,				11011		
	LAMINIE	r e	Sequentially list conditions, b									
	red nsit	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Eliter Underlying Cause (Disease or injury									
	execut in and ial-tra	Exa	that initiated events c resulting in death) Last									
094	icate be executed physician and is the burial-transit	edical	d	f								
687			IF FEMALE:	20 If you gutoome of n	roananou							
Box (death certific ne attending ed for use as	Physician/N	in the past 12 months?	3c. If yes, outcome of p 1 ☐ Live Birth 2 ☐ 4 ☐ Pregnant at tim	Fetal death	3 Ectopic pregnanc 5 Other (specify)	у		23d. Date of de Month	livery Day Year		
. B	e e e	hysi	1 Yes 2 No 9 Unknown	g 🗌 Unknown								
P.O.	es that the dea igned by the a be detached f	by P	Part II. Other significant conditions con	tributing to death but n	ot resulting in th	ne underlying cause giv	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?		
'ds,	require: been sig should b	ted						1 Yes	s 2 No 3 P	robably 4 🗆 Unknown		
Division of Vital Records,	The law resate has be	Completed						24a. Was an autopsy perform	prior to a	topsy findings available completion of cause of		
Ä	sician: The certificate rector, pag		25. Was case referred to medical			00 PI	- A Davilla (O)	1 \(\text{Yes} \) 2		2 No		
Vita	Physician: r this certifica eral director, I	To Be	evaminer?	ospital:	2 FB/Outpa	tient 3 DOA Othe	r: 4 Nursing Ho		nce 6 X Other (Spec	if _v)		
o	ding Ph h. After thi funeral	- 1	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Ye	28b. Time	e of 28c. Injury	at	28d. Describe hov		,,		
ion	ttendi death. tor: A	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be			M 1 🗆	Yes 2 No					
ĬŞ.	or Attendate deatl	Se	4 Homicide determined	street, factory, office			 Location (Street and Number or Rural Route Number, City or Town, State) 					
	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach	Medical		cian: To the best of my								
	the H hin 24 the Fi	Me	only one) 3 Certifying Nurse			dge, death occurred at the	ne time, date and pla	ace, and due to the	cause(s) and manner a			
	Sor Cor		29b. Signature and the of certifier	1		29c. License	1373	29	ld. Date signed (Mont/	n, Day, Year)		
									1/26/12 - 200 LUTHERVILLES MD 21093			
]		ERIC J. SEIFTE		0755	FALLS RO), SUTTE	= 200 L	.UTHERVILL	5MD 21093		
ì	Stat Registra	~	31. Date filed (Month, Day, Year) JAN 2 7 2012	32. Registrar's S	Signature	اردا						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Gertrude Januar y 24, 2012 McDowell 7:55P. M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Care Towson Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2 🛛 F Months Days Hours Oct13, 218-01-0195 1°925 86 Maryland Director Usual Residence of Decedent 28a-f shov item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Md. Baltimore Essex 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 38 Berkshire Road 21221 U.S.A. within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐XNo 1. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify 3 X Widowed 4 ☐ Divorced Specify. Completed White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) 9th College (1-4 or 5+) Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o မှ Henry Hebbel Gertrude Callanahan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosemarie Johnson/Daughted38 Berkshire Road Baltimore, Maryland 21221 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State January cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State injury or Gardens 27,2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) of Faith 22. Name and Address of Facility aczorowski Funeral Home, PA 21. Signature of Funeral Service Licenses any 1201 Dundalk Avenue Baltimore,Md.21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line nterval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ tro ke day 9 Medical Due to (or as a consequence of) Examiner 25 disase cochrovasen Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events southing in death). Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death 1 Yes 2 Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 4 \square Nursing Home 5 \square Residence 62 Other (Specify) \bowtie SQL \bowtie 1 Tes 2 🗷 No ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury_at 28d. Describe how injury occurred 1 Natural 5 \square Pending work? 1 ☐ Yes 2 🗆 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifi-29d. Date signed (Month, Day, Year) 58303 2012 25 19MUELY

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State Registrar AARON

31. Date filed (Month, Day, Year)

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Charles

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print),

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CHYLLES

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Octavio Blas Norman 2³4, 2012 2:57 A_M January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Gilchrist Center Towson 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Jan. 4, 1953 215-66-0334 59 **Director** Havana Cuba Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Parkville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with 9322 Waltham Woods Road 21234 United States 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. δ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 X Yes 2 □ No Specify: Cuban Specify: Hispanic "natural", 3 Widowed 4 Divorced Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Health Care Elementary/Seconday (0-12) College (1-4 or 5+) Translator Nurse/ 4 permit. Page 1 and 2 should be filed win Department of Health and Mental Hygie Important: If item 27 is marked other i any injury or other traumatic avent 4-12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ Salvador Norman Hortensia Jimenez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Norman-Wife 9322 Waltham Woods Road, Parkville, MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of January 25, 2012 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Evans^{ry,} Funce rathr place) Forest Hill, MD 4 ☐ Donation 5 ☐ Other (Specify) Chapel-Bel Air 21. Signature of Funeral Service Licenses rvans Funeral Chapel & Cremation Services 8800 Harford Rd. Parkville, MD 21234 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Interval Between diate Cause (Final Onset and Death Physician/ CIVINOSIS ase or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter on sanying Cause (Disease or iinjury that initiated events. Due to (or as a consequence of): Exami the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 for use as 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death signed by the a d be detached f Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s autopsy performed Yes 2 certificate 2 No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 - Nursing Home 5 - Residence 6 - Other (Specify) 2) No ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred After Natural 5 Pending 24 hours after death Funeral Director: A Accident
Suicide Investigation the 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 29a. Certifie 🗜 🖶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сотрыет Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 within 2

To the F only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2012

Registrar
DHMH 17 Rev 7/2009

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6701 N. Chanles ST

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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			For State		State of M	larylan		artment of I			201	2 0196	5
	Registrar 1. Decedent's Name (First, Middle, Last)					Certificate of Death				Reg. No. 2 U I 2 U 2. Date of Death 3. Time			
	Physicia Medic			ine Noel				January 24, 2012 10:50 P					
	Examir	er	4a. Facility Name (if not institution, give street and number Emeritus Assisted Living					4b. City, Town, o	r Location of Deat	h	4c. County of D		
	Funeral		5. Social Security Number 6. Sex 7.			Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.			Baltimore 8. Date of Birth 9. Birthplace (State or Foreign				
	Director		228-32-74 Usual Residence of		1 L M 2 24 F	87	Yrs.	Months Days	Hours Min.	Aug. 2	6, 1924 V	irginia	\dashv
	/land f show ed at	tor	10a. State	10b. County		10c. City	, Town or Lo	ocation				10d. Inside City Limits	
	r 28a- notifie	Direc	Maryland 10e. Street and Num	Harfo	rd	Abi	ngdon	10f. Zip Code				1 🗆 Yes 2 🖾 No	_
	with the 23a coust be	Funeral Director	3913 Lo		Road			21009			10g. Citizen of What	Country?	
	death items ner m		11. Marital Status		12. Was Decedent E Armed Forces?		. 13.	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto		pecify Yes or No- o Rican, etc.)	14. Race - A	American Indian,	٦
920	be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f sho ic event, the Medical Examiner must be notified at	ed by	1 ☐ Never Marri 3 🛭 Widowed	If Voc Cive		¥Νο		1 ☐ Yes 2 ☐XNo	Specify:		Specify:	Black, White, etc. Specify: White	
2-0	2 hour "natu edical	Completed	(Spec	15. Decedent	's Education grade completed)	16a. Dec		dent's Usual Occup	ation	rkina	16b. Kind of Busine	o. Kind of Business Industry	
21215-0036	led within 7 Hygiene. other than ent, the M		Elementary/Seco	enday (0-12)	College (1-4 or 2	5+)	life. D	NOT use retired)	-	Ü	Health C	are	
nd 2	filed wall Hyg	Be c	,	17. Father's Name (First, Middle, Last)			ruatorogy re		18. Mother's Name (First, Middle,			are	٦
Maryland	and 2 should be filed within 72 hours after death with the Maryland Fhealth and Mental Hygiene. Feath and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	2	Walter M							agdalene			4
	12 sho alth and 27 is u		19a. Informant's Na		anddaughter		1				r, City or Town, State, Maryland 2		
ore,			20a. Method of Disp	osition	Removal from State	20b. Pl	ace of Dispo	osition (Name of matory or other place		Date Date	20c. Location - City		٦
Baltimore,	permit. Page Department or Important: If any injury or once,		4 Donation	5 Other (Sp	ecify) 1	Pow	ell V	alley Men	n. Gon 1	-30-12		Gap, Virgin	iā
Bal	perm Depa Impo any ii		21. Sign ture from	eral dervice Lig	muse L		1	2. Name and Addre	sbury Roa	Comas Fur	neral Home	P.A. Zland 21009	
		П	22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Interval Between										
1.6	Physician/ Medical	3 5	Immediate Cause (F disease or condition resulting in death)	inal	_a. Dei	alit	1					Onset and Death	
-	Examiner		resulting in death)		Due to (or as	a conseque	ence of):					· ·	
	n ±	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Cause, Enter Underlying										\neg	
	executed ian and irial-transit	Examiner	Cause (Disease or injury that initiated events c. Due to (or as a consequence of):										-
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OX (attenc attenc I for us	ician	23b. Was decedent print the past 12 to 1	23c. If yes, outcome 1 Live Birth 4 Pregnant a	death 3	Ectopic pregnand Other (specify)	Ey .	23d. Date of delivery Month Day Year					
O. B	t the de by the tachec	Phys	9 Unknown		9 Unknown								-
Division of Vital Records, P.O.	res tha signed	by		-	s contributing to death b		•		ven in Part I.			e to the cause of death? Probably 4 Unknown	ı
ord	v requi	olete				(, , ,		24a. Was	an 24b. Were	autopsy findings available	-
Rec	The laviate have	Completed								autop perfo 1 □ Yes	prior prior death	to completion of cause of h? Yes 2 No	
ital	sician: certific rector,	Be	25. Was case referred examiner? 1 Yes 2		Hospital:			Oth	ace of Death (Che	ck only one)		100-000	7
of V	ig Physical dispersal di	te: To	27. Manner of Death		1 ∐ Inpati 28a. Date of inju (Month, Da	ry 2	28b. Time of	nt 3 □ DOA □ 28c. Injun	4 ∐ Nursing F / at		lence 6 Other (S) ow injury occurred	pecify) MOSY2CE	\dashv
ion	leath. or: Afte the fun	Certificate:	1 Natural 2 ☐ Accident 3 ☐ Suicide	5 Pending Investiga 6 Could no	tion	injury work? M 1 🗆 Yes 2 🗆 No							
Sivis	al or At s after or l Direct d in by		4 🗌 Homicide	determin	28e. Place of Inju	of Injury - At home, farm, street, factory, office ng, etc. (Specify)				28f. Location (S City or Tow	Rural Route Number,		
_	the Hospital or Attending Physician: The law requires that the death certificate be hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physic mpleted filled in by the funeral director, page 2 should be detached for use as the broaden for use as the broaden for use as the broaden for the funeral director, page 2 should be detached for use as the broaden for use as the broaden for the funeral director.	Medical	29a. Certifier 1	Certifying P	hysician: To the best of	my knowle	dge, death o	occured at the time	, date and place, a	and due to the car	use(s) and manner as	stated. he cause(s) and manner state	ed.
	to the ropognal or Amending Prinsicans: The law, within 24 hours after death. To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s		only no	_ Bartitying N	urse Practioner To the	bast of my	knuwledge i	29c. License	time, date and pla	see, and due to the	29d. Date signed (Mo	r de statod.	-
	->-0		▶ At	200	ly m	0		05	2303		Janvar	y 25 2012	-
5v	/		30. Name and addres	ss of person wh	o completed cause of d	eath (Item 2	23a) (Type, F	GROIN	. Che	enus s	ST TONS	50N ND)	
	Stat Registra	e :	31. Date filed (Month)		12 2. Registra	ar's Signatu	der.	Kel					
		121					10						_

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Dorthea Elizabeth Nibali 2012 Medical January 7:18 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours **Director** 550-46-2418 1 □ M 2 🕅 E 88 Jan. 25, 1923 Iowa Usual Residence of Deced 28a-f show 10a, State 10b. County notified at Director 10c. City, Town or Location 10d. Inside City Limits 1 🗌 Yes 2 🛛 No Maryland Harford Joppa 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Medical Examiner must be Funeral items 23a 513 Grigsby Ct. 21085 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Yes 2 No
If Yes, Give
Year or Dates. jo, þ 1 Never Married 2 Married 1 Yes 2 No Specify. Completed Specify: 3 X Widowed 4 Divorced Maryland 21215-003 White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than t Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Nurse Health Care is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Alfred (unk) Pedersen Maria (unk) Jensen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is any injury or other trae Mara Nibali / Daughter 468 A Prospect Ave., Hot Springs, AR 71901 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ŏ 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Arlington Nat. Cem. 1-27-12 Arlington, Virginia 22. Name and Address of Facility
McComas Funeral Home, P.A.
1317 Cokesbury Rd., Abingdon, MD 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death RGPPRATORY FAILURE Immediate Cause (Final Physician/ FOLLOWING CONGESTIVE HEART disease or condition Medical resulting in death) Examiner INGUINAL HERNIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine MultiPLE Cause (Disease or injury that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): / Physician/Medical CANCER Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 L retarded.

Pregnant at time of death in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy
 5 Other (specify) Year Month Day the Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician; The law requires 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe this certificate Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Certificate: To 1 Yes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28c. Injury at 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After Natural 5 Pending work 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the pasts of examination and/or investigation, it may specified at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 24 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ,260 GATEWAY DRIVE, SUITE 21/22 B, BEL AIR, MD 21014 ANUSHA. SIRITHAKA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State		State of M	larylan		artment of		and Me	ental Hy	/giene	е	
	Registrar 1. Decedent's Name (First, Middle, Last)						Certificate of Death					Reg. No. 2012 0146		
	Physician/ Mary Regina							Owings 2. Date of Month				eath 25	year 2012	3. Time of Death
	Exami			_	e street and number)	4b. City, Town, o		of Death		4c. County of Death				
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	Funeral Director		215-30-	7006	□ M 2 SF	ge (In yrs. Ia:	Yrs.	Months Days	If Under Hours	Min.	3. Date of Bir (Month, Data)	ay, Year)	C	rthplace (State or Foreign ountry) Vland
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	h with	Funeral Director	5517 Le	xington E	Rđ.			21207				USA		
9	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho ; the Medical Examiner must be notified at	by Fu	11. Marital Status 1 ☐ Never Marri	ed 2 Married	12. Was Decedent Armed Forces? 1 \(\sum \) Yes 2		l If	Vas Decedent of H Yes, specify Cuba	an, Mexicar	n, Puerto Rio	y Yes or No- can, etc.)		14. Race - Am Black, Whi	
8	urs af tural" al Exa	Completed	3 Widowed		If Yes, Give Year or Dates.		1	☐ Yes 2 No	Specify:				Specify: Wh:	ite
15-	72 ho n "nat ledica	nple	(Spec	15. Decedent's E cify only highest gr	ducation ade completed)		(Give k	ent's Usual Occup and of work done	during mos	t of working		16b. k	Kind of Business	
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b	12 should be filed lith and Mental Hy 27 is marked oth r traumatic event	Be	17. Father's Name (F	irst, Middle, Last)			House	Wife	18. Moth	er's Name (F	-irst, Middle,		N Home Surname)	
Maryland 21215-0036		မ	Charles	Rigo	ıs				Regi				alon)	*
lar			19a. Informant's Nar				11	g Address (Street	and Numbe	er or Rural R	oute Numbe	er, City or	Town, State, Z	ip Code)
			Wallace 20a. Method of Dispe	John Owi	ngs Sr.	OOF DI		Lexingto	n Rd.					
nor			1 🛮 Burial 2	☐ Cremation 3 ☐	Removal from State	ce	metery, crem	sition (Name of atory or other place		Dat			ocation - City or	
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Ä	permi Depar Impor any ir	1 9	De Cho	WH	of Mc	125.00		Newpira	AVA	Catons	2371 0	MI	S And Ca 21228	remations, RA.
			snock, or near	tallure. List only o	olications that caused ne cause on each line	€.	. Do not enter	r the mode of dyin	g, such as	cardiac or re	espiratory an	rest,		Approximate Interval Between
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89		an/N	IF FEMALE: 23b. Was decedent p	Jognani	23c. If yes, outcome	of pregnance	cy	Fatania auranau				1	23d. Date of de	livery
Box 68	death he atte ed for	Physician/M	in the past 12 months? 1						ther (specify)			Month Day		Day Year
o.	at the d by tl letach			cant conditions co		ut not resul	Iting in the un	derlying cause giv	en in Part I		020 Did to		on contribute to	the course of the 11-0
Division of Vital Records, P.O.	signer d be d	d by	ARM FIBRUMON 24a. Was an autopsy performed?								1 Yes 2 No 3 Probably 4			
ord	w requ	plete										24b. Were autopsy findings available		
Rec	sician: The law is certificate has be lirector, page 2 s	om									death?	completion of cause of		
E	sian: ertifica ector, p		25. Was case referred examiner?	/				26. Pla	ace of Deat	h (Check on		ZZI INC	J 1 1 1 6 8	S ZALINO
Ξ	Physic this o	မ	1 Yes 2	No			R/Outpatient		4 ∟ Nu			2	Other (Spec	ITY) GILL HEEST
n o	ding I th. After funer	Certificate:	1 Natural	5 Pending	28a. Date of injui (Month, Day		8b. Time of injury	28c, Injury work' M 1	≀at ? Yes 2□		. Describe h	ow injury	occurred	HESPICE
isio	Atten	ırtifi	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	Investigation 6 Could not be determined	28e. Place of Inju		ne, farm, stree		res Z		Location (S	treet and	d Number or Rui	ral Route Number,
DΙΧ	tal or rs afte al Dire ed in I			determined	building, etc	. (Specify)					City or Town	n, State)		a. Houte Hambol,
	To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours affer death. within 24 hours affer death. completed filled in by the funeral director, page 2 should be detached for use a	Medical	29a. Certifier (Check 2 only one) 3	Medical Examin	ician: To the best of ner: On the basis of ex e Practioner: To the	kamination a	and/or investig	ation, in my opinio	n death occ	curred at the	time date ar	nd place	and due to the	ause(s) and manner stated
	To th withir To th сопр	2	29b. Signature and til	tle of certifier		Desi Oi IIIy K	mowieuge, de	29c. License	number				and manner as e signed (Month	
			▶ %	40h.	ID			D00:	7091	7		and a		26,2012
)			30. Name and addres	ss of person who c	- 40	eath (Item 2	3a) (Type, Pri	int) 3455 1	ULLKE	WS A	VE -	SUI	TE W.	10
	Stat Registra	•	31. Date filed (Month,		32. 33 Street	r's Signatur	1 2	DIVI	IFVVF	To I M	apy u	TIVE	0100	-
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month O'Brien Thomas Matthew Jan 23. 3:59 A 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's 6704 Eilerson Street Clinton 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours **Director** 577 52 5165 1 X M 2 - F 72 Yrs Feb 8, 1939 Washington DC Usual Residence of Decede 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland must be notified at Director 1 ☐ Yes 2XX No Maryland Prince George's Clinton 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 6704 Eilerson Street United States items death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian Medical Examiner Black, White, etc. 0 þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Yes 2 No Yes, Give X Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Stromberg Sheet Metal 12 Sheet Metal Work event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ other traumatic William Matthew O'Brien Marion Edith Heathcoate 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine O'Brien (wife) 6704 Eilerson Street, Clinton, MD 20735 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Department o Important: If any injury or ō Clinton, MD 1/24/2012 Crematory Signature of Funeral Service Licer 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria 1101555 Ferry Road, Clinton, MD 20735 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
2 1/2 Years Immediate Cause (Final Physician/ METASTATIC LUNG CANCER disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of burial-transit Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical certificate be P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Year Month Dav signed by the at d be detached for Pregnant at time of death 1 Yes 2 L 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>\$</u> 1 X Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has page 2 autopsy performed? Yes 2**X** No 1 ☐ Yes 2 ☐ No this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? To Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Hodical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rita Gupta, M.D. 8926 Woodyard Road, Clinton, MD 20735

D43346

Jan 24, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ Ovando 8,201 2012 Brenda January Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Harford Aberdeen 145 Farm Road If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 217-76-2124 **Director** 1 🗆 M 2 🔀 F Yrs 55 06/11/1956 Maryland Usual Residence of Decedent or 28a-f show be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location death with the Maryland Director 1 X Yes 2 No Aberdeen MD Harford 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number iral", or items 23a or Examiner must be i Funeral U.S.A. 21001 145 Farm Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White If Yes, Give Year or Dates "natural", permit. Page 1 and 2 should be filed within 72 hours a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic event, the Medical Exconce. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Food Service 9 Customer Service Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Reese Crossiant Patsy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1803 Belt Street, Baltimore, MD 21230 Teresa Bowman / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 01/27/2012 Hanover, Maryland 4 X Donation 5 Other (Specify) Anatomy Gifts Registry Signature Juneral Service Line see 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between malignant Neoplasm Physician Unknown disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) The law requires that the death certificate be executed the burial-transi and resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\text{Nursing Home } 5 \(\text{\text{Residence}} \) Residence 6 \(\text{\text{Other}} \) (Specify) 2 🗖 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) funeral 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Certificate: within 24 hours after death.

To the Funeral Director: After t completely filled in by the funera 1 Natural 5 Pending work?
1 Yes 2 No Investigation
6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical U Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 29c. License number M Shajapahuem.D 1/26/17 00057465 Baltimore MO 21709 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W. S. Kajap akse M.D 7835 Sminh 31. Date filed (Month, Day, Year), State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			. For	State of Ma		d / Departi				•	giene	012	01970
			1 - State Registrar			Certif	icate o	f Death			Reg. No.	012	01310
# F	Physici	an	Decedent's Name (First, Middle, Lateral Property 1)						2	Date of Dea Month	Day	Year	3. Time of Death
	/Medic	al	Florence Louis			46	City Tours	, or Location of	J. Dooth	anua		ounty of Deatl	
	Examin	er	4a. Facility Name (If not institution, give	3	1.0	21 6	i 1	imor			40.0	ounty of Doub	`
¥	Funeral	A. A.	5. Social Security Number 6. S	ex 7. Age	(In yrs.		Under 1 Year	ar II Under:		Date of Birti (Month, Day	h Veerl	9. Bird	nplace (State or Foreign
1	Director		212–30–5389	□M 2 ∑ F	96	Yrs.	onths Day	rs Hours	Min.	anuary	15, 19	16 Balt	imore, Maryland
	pu ≱	}	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Location	วก						10d. Inside City Limits
	f sho	jo	Maryland Baltim			rkville							1 □ Yes 2\No
	r 28a	rec	10e. Street and Number			1	Of. Zip Code)	· · · · · · · · · · · · · · · · · · ·		10g. Citize	en of What Co	untry?
	within 72 hours after death with the Maryland ene. than "natural", or teme 23e or 28e-f show the Modical Examitar mast be notified at	Funeral Director	7841 Bagley Aven	ue			2123	4			Uni	ted Sta	ates
	r dea	Iner	11. Marital Status	12. Was Decedent Example Forces?		.S. 13. Was	Decedent of	f Hispanic Ori uban, Mexican	gin? (Specif n, Puerto Ric	y Yes or No- can, etc.)	. 14	I. Race - Ame Black, White	
36	or it	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ With Over Married	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:)	1 🗆	Yes 25	lo Specify:			S	Specify: W	nite
21215-0036	2 hours	ed t	15. Decedent's E	ducation		16a. Decedent					16b. Kind	of Business/	Industry
215	hin 72	plet	(Specify only highest gra Elementary/Secondary (0-12)	Ide completed) College (1-4or 5+)	(Give kınd life, DO i	d of work do NOT use ret	ne during mos ired)	t of working				
2	filed with Hygiene. other than	Completed	12			Secr	etary						and Masters
and	be fill hd oth	Be	17. Father's Name (First, Middle, Last, Charles F. Porte							First, Middle, Iabel S			
Maryland	should be ind Mental marked o	우	19a. Informant's Name/Relationship (19b. Mailing A	ddress (Stre						in Code)
	~ ~ ~		Carol Curtis (Ni					t Court			-		
re,	of Health Item 27 other tr		20a. Method of Disposition		20b. F	Place of Disposition	n (Name of		Dat Januar y	е		ation - City or	
Ĕ	Pages nent of ant: # It ury or o		XX Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif			dkwood Cem		1	2012	, 50,	Parkv	ille, Ma	ryland
Baltimore,	permit. Pages Department of I Important: If Ite any injury or of		21. Signature of Funeral Service Licer	nsee 1		E	vans Fu	ress of Facilit	apel &	Cremat	ion Se	rviæs-F	arkville
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused t	he deat	h. Do not enter th	800 Har	ford Ros	cardiac or r	ville, I espiratory ai	Varyla rest,	ml 21234	Approximate
į.	Physician		Immediate Cause (Final	one cause on each line				I					Interval Between Onset and Death
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Г	Examiner		Sequentially list conditions,	b									
	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	conseq	uence of):							
	be executed ician and burial-transit	xan	that initiated events resulting in death) Last	c. Due to (or as a	conseq	uence of):							
760,	0 5 0	cal		_ d									
89	The law requires that the death certificate ate has been signed by the attending phy page 2 should be detached for use as the	Medi	IE EENALE.										
Вох	ath ce ttendii	an/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2	Feta	il death 3 □Ect	opic pregna				23	Bd. Date of del Month	ivery Day Year
	the a	Physician/Med	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□ Pregnant at t 9□ Unknown	me of d	leath 5 ☐ Ot	her (<i>specify</i> ,						,
P.O.	w requires that the de been signed by the s should be detached	/ Ph	Part II. Other significant conditions of	contributing to death but	not res	ulting in the unde	rlying cause	given in Part I		23e. Did t	obacco us	e contribute to	the cause of death?
rds	quires n sign ald be	d by								10	Yes 2□	No 3□Pr	obably 4 Unknown
000	s bee	plet								24a. Was		24b. Were at	utopsy lindings available completion of cause of
Ĕ		Completed								autor perfo	rmed?	death?	2□ No
/ita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?						of Death (Check only o	ле)		
<u></u>	hysic this call dire	2	1 Tes 2 No	Hospital: 1 Inpatien			SU DOA					□Other (Spe	cify)
uc	ding F	lon:	27. Manner eath 1 atural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injury (Month, Day	Year)	28b. Time of Injury	, v	njuryat Vork? □Yes 2□		d. Describe I	now injury	occurred	
Division of Vital Records,	Attender death	flca	3 ☐ Suicide 6 ☐ Could not b	e 28e. Place of Injur	y - At h	ome, farm, street,				f. Location (Street and	Number or Ri	ural Route Number,
á	Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certificitiely filled in by the funeral director,	Certification:	4 Homicide determined	building, etc.	(Specif	(y)				City or To	wn, State)		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Examone)	nysician: To the best of miner: On the basis of and manner stat	examina	owledge, death oc ation and/or invest	curred at the ligation, in m	e time, date ar ly opinion, dea	nd place, an ath occurred	d due to the l at the time,	cause(s) a date and p	and manner as place, and due	s stated. e to the cause(s)
	within 2 To the comple	Me	29b. Signature and title of certifier		~/	<i>c</i> :		ense number			29d. Date	signed (Mont	h, Day, Year)
•			> =	> pny	1 1	Cian	400	595	40	J	900	ary	25,2012
å	/		30. Name and address of person who	completed cause of de	ath (Iter	n 23a) (Type, Prir	nt)	File	Siller.	07/01/	kir Uz	A. 11.	25,2012
1			31. Date liled (Month, Day, Year)	32. Registra	's Signs	ature	All -	-001)	UUU			CATT AN	or 110 xp. 57
	Sta Registi		IAN 2 7 2012	oz. Hegistia		Mad							-

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [1] For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 0321 AM 201 Parker anthony Medical 4a. Facility Name (if not institution, give street and numbe 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Univ Maryland MedCenter 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Director 1**XX**M 2 □ F 131-97-8838 Philadelphia, PA October 17,2011 03 07 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director Nottingham Baltimore 1 ☐ Yes 2XXNo Maryland 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 21236 Funeral United States 8101 Ridgetown Drive Apt. D Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S Was Deces? Armed Forces? Yes 2XXNo Black, White, etc. er than "natural", or the Medical Examin by 1 X Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit, Page 1 and 2 should be filed within 73 Department of Health and Mental Hyglene. Important; If Item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Secondary (0-12) Never Worked Never worked 0 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Unknown Antonia M. Parker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) 8101 Ridgetown Drive Apt D. Nottingham, MD 21236 Frances Draughton (Guardian) 20b. Place of Disposition (Name of cemetery, crematory or other 20c. Location - City or Town, State 20a. Method of Disposition Date January 27, 1 Burial 2XXCremation 3 Removal from State Evans Funeral Chapel—Bel Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2012 Λ ir Name and Address of Eacility
Evans Funeral Chapel & Cremation Services—Parkville
8800 Harford Road Parkville, Maryland 21234 21. Signature of Funeral Service Ligense 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Deuth Immediate Cause (Final Physician/ Pulmonary
Due to (or as a consequency of) Hemorrhage disease or condition Medical resulting in death) Examiner 3 Nonths Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami requires that the death certificate be executed and I-tran Due to (or as a consequence of): resulting in death) Last the burialattending physician for use as the buria Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23d. Date of delivery 23b. Was decedent pregnant Physician/ in the past 12 months?

1 Yes 2 No Month Year 5 Other (specify) Pregnant at time of death ed by the at detached f 1 Yes 2 g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Atrial Septal Defect & Overriding SVC 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy has death? the Hospital or Attending Physician: The thin 24 hours after death.

the Funeral Director, After this certificate by 1 Yes 2 No 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? 1 \(\simeg\) Yes 2 **X**No Manatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No 5 \square Pending 1 Natural
2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral C

completely filled 🔀 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number D63539 dan 24,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29 S. greene St, Suite 104, Baltimore, MD 21201 State Registrar

			For State	State c	f Marylar			nt of H e of D		and M	lental Hyg	0	010	01072
			Registrar 1. Decedent's Name (First, Middle, I	aetl		Cer	uncai	e or D	eain		2. Date of Dea	Reg. No. 3. Time of Death		
	Physicia		REGINALD	W		P	AYNE				Month JANUAR	Day	$20\overset{\text{Year}}{12}$	1:00 P M
	Medic Examin		4a. Facility Name (if not institution, g	ive street and nun	iber)		4b. City	Town, or l	Location o	f Death		4c. Cou	nty of Death	
مريد			TATE HOUSE					NTHIN		0411			E ARU	
	Funeral Director		5. Social Security Number 236–24–4794	. Sex 1 🙀 M 2 □ F	7. Age (In yrs. 88	last birthday) Yrs.	Months	r 1 Year Days	If Under 2 Hours	Min.	8. Date of Birtl (Month, Day APRIL	n , Yea <i>r)</i> 2 1923	g. Birth Cou WES	nplace (State or Foreign ntry) TVIRGINIA
			Usual Residence of Decedent		140.00									10d. Inside City Limits
	ryland -fshc ied at	Funeral Director	10a. State 10b. County			ty, Town or Lo								14 Yes 2 No
:	or 28a notif	Dire	MD PRINCE 10e. Street and Number	GEORGE 'S	S HY.	ATTSVII		p Code				10g. Citizen	of What Cou	
3	23a c	eral	2026 BARLOWE PL	ACE			1 2	0785			Ì	USA		
	items items		11. Marital Status	12. Was Dece	edent Ever in U.	S. 13.\	Was Dece	dent of His	spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)		Race - Amer	
9000	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Inmportant: I filem Z7 is marked other than "naturaly", or items 29a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	d by	1 ☐ Never Married 2 🔀 Marrie 3 ☐ Widowed 4 ☐ Divorced	d 1 X Yes If Yes, Giv	e No AI	RFORCE		2 🌠 No		,	,	Spec		BLACK
3	hours natura ical E	Completed	15. Decedent			16a. Deced	dent's Usu	al Occupa	ation		- X	16b. Kind o	f Business I	ndustry
2 2	e. an "r	dwo	(Specify only highest Elementary/Seconday (0-12)	grade completed, College (1		(Give	kind of wo O NOT us	ork done di e retired)	uring most	of worki	ng			
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ב ב	be file ental H ked of c ever	To B	17. Father's Name (First, Middle, La	st)					ROSA		e (First, Middle, . F .	iviaiden Surrie	атте)	
<u> </u>	2 should to the and Me 27 is mark traumation		JAMES M. PAYNE 19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Addres	s (Street a	nd Numbe	r or Rura	I Route Number	r, City or Towi	n, State, Zip	Code)
Ξ.	id 2 st salth a n 27 is ertra		MARY T. PAYNE/W	IFE		2026	BARI	OWE 1	PLACE	HYA	TTSVILL	E,MARY	LAND	20785
	je 1 and t of Hea If item or other		20a. Method of Disposition 1 Disposition	B Removal from	State	Place of Dispo cemetery, crer	natory or	other place			Date	20c. Location		
Dalltilling	nt. Page 1 rtment of rtant: If it njury or o		4 Donation 5 Other (Sp		FT	. LINCO	OLN C	EMET	ERY 1	/30/				ARYLAND L HOME, INC.
0	permit. Departin Importa any inju once.		21. Signature of Funeral Service Lic	ensee										AND 20785
		Г	23a. Part 1. En et the isea e, or c shock, otheart fulure List on	omplications that	caused the dea	th. Do not ent	er the mo	de of dying	g, such as	cardiac c	r respiratory an	rest,		Approximate Interval Between
P	hysician/ Medical		Immediate C use (Fin V disease or condition resulting in death)	_ a	PERTENS									Onset and Death
- and	Examiner		resulting in deathy		or as a consec NGESTIV		Τ ΈΔΊ	LURE						
		ner	Sequentially list conditions, if any, leading to inmediate	D. —	(or sis = nonsec		I FA.	LLOKL						
1	oured nd ransit	Examiner	it any, leading to in insolate cause. Enter Underlying Cause (Disease or iinjury that initiated events	c					_					
	e exec cian al urial-t	a E	resulting in death) Last	Due to	(or as a consec	quence of):								
	physic physic the b	edical		d										
0	cerrin anding use as	N/U	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	tcome of pregn Birth 2 Fe	ancy	7 Ectopic	pregnanc	v			23d.	Date of del	ivery
DOX	dearn he atte ed for	Physician/Me	in the past 12 months? 1 Yes 2 No 9 Unknown		nant at time of		Other (s		,				Month	Day Year
j :	ar me d by tl letach	Phy	Part II. Other significant condition	s contributing to d	leath but not re	sulting in the	underlying	cause giv	en in Part	I.	23e. Did to	obacco use c	ontribute to	the cause of death?
ທົ່	signe	d by			•	, -11					1 🗆	Yes 2□N	lo 3 🗆 Pi	robably 4 Unknown
ecords,	v requ	olete									24a. Was		b. Were au	topsy findings available
Hec	the lay	Completed									autor perfo 1 \square Yes	rmed?	death?	2 No
VItali	ertifica ector, p	Be	25. Was case referred to medical examiner?	Hospital:					ace of Dea		k only one)			
>	Physic this c	2	1 Yes 2 No	1 28a. Date	Inpatient 2	ER/Outpatie		Othe 28c. Injury	4 🗀 Ni		ome 5 Residence Residence Residence 28d. Describe R			HOSPICE HOUSE
ח סו	th. : After : fune	cate	1 Natural 5 Pending 2 Accident Investig.	(Mor	nth, Day, Year)	injury	М	work	Yes 2		Zod. Describe i	low injury occ	Julica	
DIVISION	r Atter ter des rector	Certificate:	3 Suicide 6 Could n 4 Homicide determin	ot be 28e. Place	e of Injury - At h		reet, facto	ry, office			28f. Location (S		mber or Rui	ral Route Number,
5	to the Hospital or Attending Priysician: The law requires that the clearlicate be executed within 24 hours after death. Within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1 X Certifying	Physician: To the			Decrinad :	at the time	date and	place or			anner ac ctr	ated
:	E Hos 24 ho Fund leted	Medical	(Check 2 Medical Ex	aminer: On the ba	sis of examinati	on and/or inves	stigation, i	n my opinic	on, death or	ccurred a	t the time, date a	and place, and	due to the	cause(s) and manner stated.
;	No the vithir comp	2	29b. Signature and title of certifier	2		,		c. License		- 1 a		29d. Date sie	aned (Month	n, Day, Year)
				J. B.				13	155	//		J91	uny	25,2012
			30. Name and address of person w					CIEN	RIIDN	TF M	ΔΡΥΤ.ΔΝΌ		,	
	Sta	te	31. Date filed (Month, Day, Year)		Registrar's Sign	ature			TOWN	11 و ند	TILL			
	ાત Registr		O. N	/ .		1 100	execut	7						

DHMH 17 Rev 7/2009

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Elizabeth June Przybylo 2:28 P Medical Jan 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Bradford Oaks Nursing home Clinton Prince George's If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Hours Director 357 12 5830 85 1 □ M 2 🗶 F May 14, 1926 Wisconsin Usual Residence of Decedent f show notified at 10a. State 10b. County 10c. City, Town or Location rector 10d. Inside City Limits 28a-f Prince George's Marvland Upper Marlboro 1 Yes 2 No $\bar{\Box}$ 10e. Street and Number 10f. Zip Code Mental Hygiene. narked other than "natural", or items 23a or natic event, the Medical Examiner must be r 10g. Citizen of What Country? Funeral 10310 Cedar Knoll Court 20772 United States death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 XX If Yes, Give XX Year or Dates. 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 Widowed 4XX Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygie is marked other Federal Reserve Wire Transfer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev 2 Stephen Brantner Florence Pidd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Halikman (daughter) 10310 Cedar Knoll Court, Upper Marlboro, MD 20772 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 M Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Resurrection Cemetery 1/31/2010 Clinton, MD 21. Signat re of Funeral Service Licens 22. Name and Address of FacilityLee Funeral Home, Inc 6633 Old Alexandria M01551 Ferry Road, Clinton, MD 20735 23a. Pag. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Onset and Death disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): The law requires that the death certificate be executed the burial-tra Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery for in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy 5 Other (specify) Month Pregnant at time of death Day Year ed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform certificate Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: (2 1 ☐ Yes 2 ☐No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death. Funeral Director: After this 4 Nursing Home 5 Residence 6 Other (Specify, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check within 2. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie anna m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10701 Civingston Rose, Fort WASDuctor prompted I ANNON MA 31. Date filed (Month, Day, Year) State

ORIGINAL

Registrar
DHMH 17 Rev 06-2011

12-00575

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	State of Maryland / Departmen	t of He	ealth and	Menta	al Hygien

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Rolando Pollack	State of Maryland / Department of Factor State 1- For State Certificate of L)eath	2012 01971
Physician/ Medical Examine		2. Date of Dea	ath Day 2012ear 3. Time of Death
and the second s		City, Town, or Location of Death Baltimore	4c. County of Death
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 220-64-83-46 1 M 2 F 55 Yrs.		rth (MM/DD/YYYY) 9. Birth place (State or Foreign Country) Mary kind
i se.	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	Baltimore	10d. Inside City Limits 1 Yes 2 No
the Maryland or 28a-f sh uified at once	10e. Street and Number 1400 E. Madjson St. Apt. 706	0f. Zip Code 21205	log. Citizen of What Country?
eath with the items 23 ust be no	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No	Decedent of Hispanic Origin? (Specify Yes or No specify Cuban, Mexican, Puerto Rican, etc.)	White, etc.
2 hours after de "natural", or L'Examiner m	3 Widowed 4 Divorced If yes, Give Year or Dates:	es 2 Mo specify: Usual Occupation (Give kind of work done of working life. DO NOT use retired)	Specify: 16b. Kind of Business/Industry
5-0036 lied within 72 hour Hygiene. lother than "natu the Medical Exar		18.Mother's Name (First, Middle,	1. 1
ore, MD 21215-00; se I and 2 should be filed with of Health and Mental Hygiene If iten 27 is marked other ti ther traumatic event, the Mea		Elizabeth Ki ddress (Street and Number or Rural Route Num E. Madiser St. Apri	mber, City or Town, State, Zip Code)
more, M Pages 1 and 2 ent of Health unt: If item 2	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition crematory or other		20c. Location - City or Town, State Battimore, Maryland
Baltimo	21. Signature of Funeral Service Licensee Parker 35)	and Address of acility parker to	argraf Home P.A. 21229 affinore, Maryland
Physician Vedical ≛xaminer	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Atherosclerotic Cardiov		rest, shock, or heart Approximate Interval Between Onset and Death
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executed an and al-transit			
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ding Ph	1 Ves 2 No Inpatient 2 ER/Outpatient 3		Residence 6 Other:
Division To the Hospital or Attentia within 24 hours after death. To the Funeral Director: A completely filled in by the for	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, (Specify)		Street and Number or Rural Route Number, City State)
To the Hospi within 24 hou To the Funer completely fil	200 Codifier	d at the time, date and place, and due to the cau h, in my opinion, death occurred at the time, date	se(s) and manner as stated. e and place, and due to the cause(s)
• ***	29b. Signature and title or certifier	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) January 21, 2012
3√		/. Baltimore Street, Baltimore, MD 2	1223
State Registra	31. Date filed (Month, Day, Year) JAN 2 7 2012 32 Registrar's Signature		
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		- For State egistrar		Cei	rtificate d	of Death			Re	j. N o.			
Physician ical Examine	n/ er	Luis A. Padi	11a						2. Date of Death Month January 19	Day Year , 2012	0635 HIS		
¥.	4	ta. Facility Name (if not institution 124 Kinship Road #2	· -	imber)		4b. City, Town Dundalk					e County		
Funeral Director	- 1	5. Social Security Number 6. Sex 1. Age (In yrs. last birthday) 73 Yrs. Social Security Number 1. Age (In yrs. last birthday) 8. Days Hours Min. Jan. 17, 1939 Foreign Cour									9. Birthplace (State or Foreign Country) Puer to		
Aaryland 28a-f show any 1 at once.		, , , , , , , , , , , , , , , , , , , ,	imore		, Town or Loc ndalk				1	10d. Inside City Limit			
the Maryl	Director	124 Kinship	Road,Apt.2	2B		10f. Zip Co			10	g. Citizen of Wh	at Country?		
e € 2 .	Lane	1. Marital Status 1 Never Married 2 N 3 Widowed 4 N Div		2 X No	If	Yes, specify C	uban, Mexic	an, Puerto f	ecify Yes or No- Rican, etc.)	White	- American Indian, Black, o, etc. Black		
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ould be filed within a Mental Hygiene. marked other that is event, the Medica	g	17. Father's Name (First, Middle Marcial Parri	lla		Lan Mari		Fi	Lomina	Padil				
and 2 shoult Health and M Item 27 is ma traumatic e	_ - -	19a. Informant's Name/Relations Drusilla Padi 20a. Method of Disposition	lla		1504 Place of Disp	Chilwo	rth A	venue		e River	n, State, Zip Code) , MD 21220 City or Town, State		
permit. Pages 1 are Department of He important: If ite njury or nther tr		1 Burial 2 Crematio 4 Donation 5 Other S 21. Signature of Funeral Service	Specify:			emation					r, Maryland		
nysician	1	Muchael I M 23a. Part I. Enter the disease, or failure. List only one cause	r complications that of	aused the death	n. Do not ente	the mode of d	rford ying, such a	Road, s cardiac or	Baltin respiratory arre	ore, Ma	Between Onset an		
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e death certificate be executed the attending physician and red for use as the burial - trans	Clan	F FEMALE: 3b. Was decedent pregnant in t past 12 months? 1 Yes 2 No 9 Un	the 1 Live t	nant at time of de	2 🔲 !	Fetal death Other (Specify)		opic pregnar	ncy	23d. Date of Month	Day Year		
es that th igned by be detach	<u>≥</u>	Part II. Other significant condi			resulting in the	e underlying ca	use given ir	Part I.		2 No 3	bute to the cause of death? Probably 4 Unknown		
The law requires that th cate has been signed by page 2 should be detach	Completed								24a. Was a autops perform	n <u>ed</u> ? d	Were autopsy findings availabenor to completion of cause of death? Yes 2 No		
ysician: The his certificate director, page	8	25. Was case referred to medical examiner? 1 Yes 2 No	Illospital:	Inpatient 2	ER/Outpatie			ath (Check o		Residence 6	Other: Scene		
ling Ph After t funeral	ation: To	27. Manner of Death 1 Natural 5 Pen	nding estigation	n, Day,Year)	28b. Time o	1	. Injury at W	☐ No	_	ow injury occurre			
hour y fill	Certification:	3 Suicide 6 Cou	28e. Place (Specify) Physician: To the beautiful and the properties of the period of						or Town, St	ate)	er or Rural Route Number, Ci		
To the Hos within 24 ho To the Fun completely	edica	(Check only one) 2 Medical Exception Medical Exception on the control of the cont	aminer: On the basis and manner s ier	of examination a	and/or investig	gation, in my op	cense num	occurred at	t the time, date a	and place, and d	ed (Month, Day, Year)		
		30. Name and address of person					D.C.M.E.	e MD 21	223	January 20), 2012 		
		Ling Li, MD Assista		connect MOD	vv. Daliliff	VIE OHEEL	ப்பார்ப்பட	ر ا کے الالا ، د					
Sta Registr	_	31. Date filed (Month, Day, Year,		givrar's Signat) No. 1.		,					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle_Last) 3. Time of Death Month Physician/ 2012 25 M ar Gur d W Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** University of Maryland (Seltimere Medical Cente If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Jan. 8, Months Hours 1**X** M 2 □ F 78 Maryland 214-30-6988 Ĩ934 **Director** Usual Residence of Deced items 23a or 28a-f show ner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State with the Maryland Director 1 X Yes 2 No Baltimore MD 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code Funeral **USA** 21223 1246 Sargeant St. · death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Examiner Armed Forces?

1 Yes 2 XNo If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or by 1 Never Married 2 X Married Maryland 21215-0036 72 hours after If Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry th and Mental Hygiene.

I is marked other than traumatic event, the Me life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Freight Company Truck Driver 8 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Keil Marion permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked Parker Lloyd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1246 Sargeant St., Baltimore, MD 21223 (Wife) Shirley J. Parker other Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State Baltimore_tcrematory injury or Baltimore, Maryland 1/27/12 Loudon Park 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Loudon Park Funeral Home any 3620 Wilkens Ave., Baltimore, MD 21229 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Lardias 0 45 disease or condition Medical resulting in death) Due to (or as a consequence of *Examiner ardioVascular Sequentially list conditions, If any, leading to immediate cause. Enter Underlying sician and burial-transit Exami executed Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buris Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 □ Live Birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death signed by the at Id be detached f 1 Yes 2 9 Unknown 2 No P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? è 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has builtautopsy performe Yes 2 1 Yes 2 No 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 FR/Outpatient 3 DOA |은 this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 Yes 28b. Time of 28d. Describe how injury occurred I Director: After to a in by the funeral Certificate: 1 Natural 5 Pending 2 🗌 No after death 2 ☐ Accident 3 ☐ Sulcide 4 ☐ Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) filled in within 24 hours a

To the Funeral C

completely filled To the Hospital Medical 🖒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

Registrar

31. Date filed (Month, Day, Year)

owill The

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MB

32. Regist

Salpmore

Jan 24

Floyd HOWELL, MD

mo 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JANUARY 2012 01:45A .ISA J0 PATE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death BALTIMORE GILCHRIST HOSPICE CARE TOWSON Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Funeral 1 M 2**XX**F Months Days 267-11-8718 44 08/23/1967 Director Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD **BALTIMORE** OWINGS MILLS 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? er than "natural", or items 23a on the Medical Examiner must be Funeral 2304 CAVESDALE ROAD 21117 USA death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Force Black, White, etc. 1 Never Married 2 X Married ð Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. WHITE Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) CLINICAL PSYCHOLOGIST PSYCHOLOGY should be filed with and Mental Hygien 7 is marked other th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev ည J. STANLEY BERTMAN SANDRA SCHWARTZ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DREW PATE/HUSBAND 2304 CAVESDALE ROAD, OWINGS MILLS, MD 21117 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 Removal from State CARROLL CREMATION 01/25/2012 HAMPSTEAD, MD 4 Donation 5 Other (Specify) 21. Signature Funeral 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ MelanonA disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami that initiated events Due to (or as a consequence of) resulting in death) Last burial physician s the burial Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 1 Yes 2 No 9 Unknown the Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 this certificate 1 Yes 2 No To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No nours after death.

neral Director; Affilled in by the fur Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) hin 24 hours a the Funeral C npleted filled i Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check within 2.

To the F
complet Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature ad title of certifie 29d. Date signed (Month, Day, Year)

State

HARON

31. Date filed (Month, Day, Year)

6701

SW

32. Registrar's Signature

· Charles

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2012

424

			State of Maryland	/ Depa	artment o	f Health	h and M	lental Hy	giene			070
			1 - State Registrar	Cer	tificate o	f Death	7		Reg. No.	<u> 201</u> 2	2 0 1	9/9
	Physicia	ın/	1. Decedent's Name (First, Middle, Last) FRANCES V. RANDOLPH					2. Date of Dea Month	Day	Year	3. Time o	
	Medio Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Towr	n. or Locatio	on of Death	JANUAR		2012 County of Dea	1:35	P M
-	E Adiiiii		HOLY CROSS HOSPITAL			ER SP				NTGOME:		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last	birthday)	If Under 1 Ye Months Day		der 24 Hrs.	8. Date of Birt	h	9 8	irthplace (State	or Foreign
	Director		577-40-8930 1 □ M 2 🕱 F 82 Usual Residence of Decedent	Yrs.	I WOULD SE	, Tiour	141111	(Month, Day MARCH	23 1	929 WĂ	SHINGTO	N,DC
	show at	o		Town or Loc	eation			L			10d. Inside C	ity Limits
	//anyla //8a-f tified	rect	MD PRINCE GEORGE'S BO	WIE							1X□ Ye	s 2 🗆 No
-	a or 2 be no	Ö	10e. Street and Number		10f. Zip Cod	е			10g. Citiz	zen of What C	ountry?	
3	ns 23 nust	Funeral Director	4208 HUNTCHASE DRIVE		207	20			USA			
	r deat r iten iner r		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes 2 No	13. V	Vas Decedent of Yes, specify Co	of Hispanic (uban, Me xic	Origin? (Spe can, Puerto	cify Yes or No- Rican, etc.)	1	4. Race - Am Black, Whi		
ဗ္ဗ	s affe al", o Exam	d by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.	1	☐ Yes 2 X	No Speci	ify;		s	Specify:	BLACK	
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2	inled within 72 hours after death with the Maryland the Hygiene. 4d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Be C	10th	DIET	ITION	10.14		(First Middle		VERNMEI	TV	
ਰ ਹ		To	UNKNOWN					e (First, Middle, SMITH	waiden S	urname)		
ary	z should by th and Mer 7 is marke traumatic		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Stre			l Route Number	: City or T	own, State, Z	ip Code)	
Σ	nd 2 sl salth a n 27 i		DAVID GURLEY/SON	420	8 HUNTC	HASE	DRIVE	BOWIE,	MARYI	LAND 20	720	
Baltimore,	ge 1 and 3				sition (Name of natory or other p	olace)		Date	20c. Loc	cation - City o	r Town, State	
	t. Page tment c tant: If ijury or		4 Donation 5 Other (Specify)	RMONY	CEMETE	RY	2/3/2				<u>IARYLANI</u>	
Bal	permit. Page Department Important: I any injury o		21. Signature of Funeral Service Licensee		. Name and Add			B. JE:				
			23a. Part 1. Enter the disease, or complications that caused the death. I							L, MARYI	AND ZU	
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6876U	incare ig phy as the	Medi	US SERVICE						1			
ž ž	r use	an/I	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy		Ectopic pregna	ancv			2	3d. Date of de	elivery	
BOX	the att	Physician/Me	1 ☐ Yes 2 ▼ No 9 ☐ Unknown 4 ☐ Pregnant at time of dea	th 5 🗆	Other (specify))				Month	Day	Year
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S, F	signe Id be	d by	END STAGE RENAL DISEASE					1 🗆 🗅	∕es 2 □	No 3⊠i	Probably 4 🗆	Unknown
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Physic	this ca	욘	1 Yes 2 No Hospital: 1 Na Inpatient 2 ER		t 3 🗆 DCA			me 5 Resid			cify)	
n or	After funer	ate	1 Natural 5 ☐ Pending (Month, Day, Year)	b. Time of injury		jury at ork? Yes 2	_	28d, Describe h	ow injury	occurred		
DIVISION	r deal	Certificate:	2	, farm, stre			_	28f. Location (S	treet and	Number or Ru	ıral Route Numi	ber,
± €	rs afte al Dir		building, etc. (Specify)					City or Tow	n, State)			
Hospi	Within 18 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge (Check 2 Medical Examiner: On the basis of examination are	nd/or investi	igation, in my op	inion, death	occurred at	the time, date as	nd place, a	and due to the	cause(s) and ma	anner stated.
4	ithin 2 o the	ž	only one) 3 Certifying Nurse Practitioner: To the best of my leading to the best of my leading to the best of the best of my leading to the best of th	knowledge,		at the time,				signed (Mont		
	• ≶ ⊬ Ö		Francis Freesinger MD	,		0704		[1/2	5/2010	,, , , , , , , , , , , , , , , , ,	
			30. Name and address of person who completed cause of death (Item 23		rint)				-100	-12012		
			FRANCIS A. FREISINGER MD 1500			ROAD	SILVE	ER SPRIM	NG, MA	RYLAND	20910	
	Stat Registra		31. Date filed (Month, Day, Year) JAN 2 7 2012 32. Registrar's Signature	A. A.	barker							

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Obe CTOO AM teway 2012 Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City Town, or Location of Death 4c. County of Death GENERA Manyland Balt. more If Under 1 Year I f Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min Director 1 🗆 M 2 🖫 sidence of Decedent 28a-f show 10a. State 10b. County at Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified 1 Nes 2 No Itimor 10e. Street and Number 10g. Citizen of What Country? Completed by Funeral ral", or items 2 Examiner mus Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give "natural", 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) /Secondary (0-12) Ome Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည traumatic 19a. Informant's Name/Relationship (Type, Print) (Husbaud) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a other 20a. Method of Disposition
1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State Department of H Important: If ite any injury or oth 20b. Place of Disposition (Name of cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) LADAIK 21. Si nature of Fu eral Service Lice Home, P. A. all 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on e. ch line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine signed by the attending physician and deed be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical e Hospital or Attending Physician: The law requires that the death certificate be 124 hours after death.
P. Property of the physician of the property of the propert Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director, After this certificate has I completely filled in by the funeral director, page 2: autopsy performed Yes 2 2 🗌 No 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No ၉ 1 Inpatient 2 N Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending work?
1 Yes 2 Accident
3 Suicide
4 Homicide М 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my known only one death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 2 29d. Date signed (Month, Day,

State Registrar 30. Name and addless of person who con

Thampson-Richards

Division

2121

eted cause of death Ntem

1501

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1- For State Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) sician/ 1127 hrs January 12, 2012 xamine Dorothy Ridgely 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Temple Hills 6803 Cool Ridge Road 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Washington If Under 1 Year If Under 24Hrs. 7, Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours Country) Director June 30, 1920 ĎС 91 578 24 0224 1 M 2 X F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 Yes 2 XX No Temple Hills Prince George's Maryland Maryland Pages I and 2 should be filed within 72 hours after death with the Maryland trenet of Health and Mental Hygiene.

Tant: If item 27 is marked other than "natural", or items 23a nr 28a-f shu or other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20748 6803 Cool ridge Road 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Ongin? (Specify Yes or No Funeral 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Armed Forces? 1 Never Married 2 Married 2 XX No Yes 1 Yes 2 No specify: Specify: White If Yes, Giva Yaar 3XX Widowed 4 Divorced 2 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Cashier Giant Baltimore, MD 21215-0036 12 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gladys M. Tweedale Be Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ۵ 6803 Cool Ridge Road, Temple Hills, MD 20748 Barbara Crawford (daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Maryland Veterans Cemetery | 1/25/2012 Cheltenham, MD 4 Donation 5 Other Specify: 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria 21. Signature of Funeral Service Licer Ferry Road, Clinton, MD 20735 m00257 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Retween Onset and failure. List only one cause on each line Death /Medical Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the burial - transit Physician/Medical AMENDED 23a, 27, per me, g924 2-23-12 sm X UNPENDED The law requires that the death certificate be Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: Day Year 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown <u>۾</u> Completed 24b. Were autopsy findings available 24a Was an has been prior to completion of cause of autopsy death? performed 2 No ✓ Yes 2 No 1 🗸 Yes certificate 26.Place of Death (Check only one) 25. Was case referred to medical the Hospital or Attending Physician: BB Other Nursing Home 5 Residence 6 🗸 Other: Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 this 1 Yes 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury After 27. Manner of Death Certification: 1 Yes 2 No 1 X Natural 5 Pending death. Director: d in by the f 2 _ Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 6 Could not be on 24 hour.

o the Funeral Drompletely filler determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d, Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier January 14, 2012 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Ana Rubio MD.

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

31. Date filed (Month, Day, Year)

ORIGINAL

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Roane Month Dav Mary Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death MANORCARE NURSING CENTER @ ROLAND Ρ BALTIMORE If Under Social Security Number Year If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** Age (In yrs. last birthday) 1 □ M 2 □XF Months Days Hours Director 230-07-5562 -7-1920 Usual Residence of Decedent 28a-f shov 10a, State 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location Director MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3000 TOWANDA AVE APT 420 21215 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 XNo If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: BLACK "natural", 3 V Widowed 4 □ Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) other traumatic event, the -12-DOMESTIC HOUSEKEEPING Be Department of Health and Montal H Important: If item 27 is marked oth any injury or other treesones 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 THOMAS FAUNTLEROY MARY TAYLOR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KEVIN POPE (GRANDSON) 9101 SYLVAN DALE RD. RANDALLSTOWN, MARYLAND 21133 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 D Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) BEULAH CEMETERY 1-28-2012 LIVELY, VIRGINIA 21. Signatur of Funeral Service Licensee **JONATHAN** D_{\bullet} HIBNER Name and Address of Facility REDD FUNERAL SERVICE 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shork, or heart fallure. List only one cause on each line Immediate Cause (Final Congestine Mast failure Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Libro llation Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury sician and burial-transit Gastritis death certificate be executed Eroune that initiated events resulting in death) Last physician Physician/Medical 68760 as the use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy for in the past 12 months? Pregnant at time of death 5 Other (specify) Month 1 Yes 2 No Yes g 🗌 Unknown detached P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? þ Records, or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Oriknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed' Yes 2 No 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) examiner? 1 Yes Other: 2 1 Inpatient 2 ER/Outpatient 3 I 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: s after death.

I Director: After the in by the funera 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred ↑ Natural 5 Pending Division 1 🗌 Yes 2 No Accident Investigation Could not be 4 Homicide in by 1 Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Funeral L Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. title of certifier 29b. Signature an 29d. Date signed (Month, Day, Year) M.D. D72536 1-25-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 821 N Euton Street Baltimorre SUMIT BYUTANI

Year

2017

N/A

5:30AM

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between

Onset and Death

Day

2 🗌 No

MD

death?

Year

1 X Yes 2 ☐ No

VIRGÍNIA

DHMH 17 Rev 7/2009

State Registrar

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			For State		State of N	1arylan		artment of F tificate of L		nd M	ental Hy	2	יחוי	2 01983
			Registrar 1. Decedent's Name	(First, Middle, Last)			uncate of L	Jeaur		2. Date of De		UI	3. Time of Death
	Physici Medi	cal	JERRY	ALAN	RAND	ALL					Janua Janua	ey 25	4 201	2 13:02PM
24	Exami		4a. Facility Name (if r	+ospital	of Bar	tim		Sarco.	noce	Ci	ly		unty of Dea	ath
	Funeral Director 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 X M 2 F 54 Yrs. 54 Yrs. 6. Sex 7. Age (In yrs. last birthday) 1 X M 2 F 54 Yrs. 6. Sex 7. Age (In yrs. last birthday) 1 X M 2 F 54 Yrs. 6. Sex 7. Age (In yrs. last birthday) 1 X M 2 F 54 Yrs. 6. Sex 7. Age (In yrs. last birthday) 1 X M 2 F 54 Yrs. 6. Sex 7. Age (In yrs. last birthday) 1 X M 2 F 54 Yrs. 7. Age (In yrs. last birthday) 1 X M 2 F 54 Yrs.											rthplace (State or Foreign ountry) MD		
	land show dat	to		10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
	e Mary r 28a-i notifie	Director	MD 10e. Street and Numl	BALTIN	IORE		CATON	SVILLE						1 🗆 Yes 2 🔀 No
	s filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral		DERICK RO	AD. APT	R		10f. Zip Code	21228			10g. Citizen	of What Co JSA	ountry?
	death items ner m	Fun	11. Marital Status		12. Was Decedent Armed Forces	Ever in U.S	3. 13. V	Vas Decedent of Hi Yes, specify Cuba		n? (Speci	ify Yes or No-	14.	Race - Ame	erican Indian,
336	al", or	d by	1 X Never Marrie 3 ☐ Widowed 4		1 Yes 2 X If Yes, Give Year or Dates.			☐ Yes 2 XNo		i derio i i	ican, etc.)	Spe	Black, Whit c <i>ify:</i>	
5-0036	hours natur	plete		15. Decedent's Ed	ucation			lent's Usual Occupa		· · · · · · · · · · · · · · · ·		16b. Kind o	of Business	WHITE
2121	ithin 72 ene. • than the Me	Completed	Elementary/Secon		College (1-4 or	5+)	life. D	kind of work done a D NOT use retired) LESMAN	uring most o	n working	3	A T T T	romon.	TT 12
d 2	be filed within antal Hygiene. ked other that cevent, the N	Be	17. Father's Name (Fi	rst, Middle, Last)			<i>3B</i>	LESMAN	18. Mother's	's Name (First, Middle,	Maiden Sum	TOMOB : ame)	ГГС
Maryland		오	CHARLES			RAND	ALL		ELSI	E			(GERSTL
Mai		1	19a. Informant's Nan	ne/Relationship (Typ RANDALL /	, ,			g Address (Street a						
ore,	of Healt of Healt fitem 2 r other		20a. Method of Dispo	sition		20b. P	lace of Dispos	sition (Name of patory or other place	:	Da				r Town, State
Baltimore,	permit. Page Department o Important: If any injury or once.		4 Donation	Cremation 3 1 5 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		′ I	ROLL C	REMATION	INC 0					AD, MD
Bal	permit. Departr Import any inj		21. Signature of Fund	eral Service License	Cathle			Name and Addres						
			23a. Part 1. Enter the shock, or heart	e disease, or compl failure. List only on	cations that cause	d the death		900 REIST r the mode of dying					وباللا	Approximate
Salay	Hysician/		Immediate Cause (Fi disease or condition resulting in death)	nal	An	roxic	lu	en frijer	My.					Interval Between Onset and Death 6 down
-	Medical Examiner		resulting in death)		Due to (or as	a consequ	ence of):							U
1		iner	Sequentially list cond if any, leading to imm cause. Litter Underly	nediate	Due to (or as	a consequ	ence of):						- 7	
	executed an and ırial-transit	Examiner	Cause (Disease or in that initiated events resulting in death) La		Due to (or as	a consequ	ence of):							
00	e be e) ysician ne burit			L,	i					_				
3876	ertificat ling ph	/Mec	IF FEMALE:		2- 16									
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Luneral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the but	Physician/Medical	23b. Was decedent point the past 12 moint 1 Yes 2 Unknown	onths?	3c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Feta	Ideath 3 🗌	Ectopic pregnancy Other (specify)	У				Date of de Month	livery Day Year
Division of Vital Records, P.O.	requires that to been signed by should be dete	ا ۾	Part II. Other signific	ant conditions cor ty me In ce a		out not resu	ulting in the ur	nderlying cause give	en in Part I.					o the cause of death?
Recor	The law re ate has be page 2 sho	Completed	Sulsta	ince a	rye.					_	24a. Was autop perfo 1 Yes	rmed?	prior to death?	topsy findings available completion of cause of s 2 ☑ No
/ital	sician: certific	m	25. Was case referred examiner? 1 ☐ Yes 2 ☑	. 177	ospital:			Otho	ce of Death (
of	ng Phy ter this ineral c	ite: To	27. Manner of Death	5 Pending	28a. Date of inju	iry	ER/Outpatient 28b. Time of injury	28c. Injury	at			ence 6 🗆 Cow injury occ		cify)
sion	death. ctor: A y the fu	Certificate:	2 Accident 3 Suicide	Investigation 6 Could not be	28e. Place of Inj			M 1 🗆 Y	Yes 2 No					
Divi	tal or A rs after al Direct led in b		4 Homicide	determined	building, et	c. (Specify)	ne, iaim, sire	et, factory, office		28	f. Location (S City or Tow		nber or Ru	ral Route Number,
	e Hospi 124 hou e Funer	Medical	(Check 2 L	Certifying Physic Medical Examine Certifying Nurse	r: On the basis of e	xamination	and/or investi-	pation, in my opinior	 death occur 	rred at th	e time, date a	nd place and	due to the	cause(s) and manner stated
	To the within To the comp		29b. Signature and titl	e of certifier				29c License	number			20d Date sig	ned (Month	h Day Voorl
	CP		30. Name and address	Jonn's K			020/75: 5	KES	-00	00		Jam	rery	25 42012
	/		Venkata	Angile	ula m	1BBS	Sa) (Type, Pr	Proj H	ospita	al d	of Bal	time	re.	
	Stat Registra	e ir	31. Date filed (Month, JAN	2 6 2012	32. Registra	ar's Signatu	barks	1						
DUIN	11.12 D	044			,	-								

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			Please	Type or Pri							egible.	
		For State Registrar		State of M	arylar		artment of I rtificate of I	⊣ealth and N Death	-	giene _{Reg. No.} 2	012	01984
		Decedent's Name	e (First, Middle, La	ast)			tinoate or i		2. Date of Dea	ath	O I L	3. Time of Death
Physicia Medic		Stacy F	Rea Sand	lers					January	y 25,	2012 Year	8:25 A M
Examin	er	Casey Ho	ouse	e street and number)			4b. City, Town, o	r Location of Death Le			unty of Death tgomer	
Funeral Director		5. Social Security N 114–62–8		Sex 1 □ M 2 X F	e (In <i>yrs. I</i>	las <i>t birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da Feb 17	th y, Ye <i>ar</i>) 1978	nplace (State or Foreign ntry) York	
nd now	ŗ	Usual Residence of 10a. State	Decedent 10b. County		10c Cit	ty, Town or Lo	cation					10d. Inside City Limits
arylar ta-fsk ified	ecto	MD	Montgon	erv		thersb						1 🗆 Yes 2 🔀 No
th with the Maryland ms 23a or 28a-f show must be notified at	Funeral Director	10e. Street and Nur 18622 Wa	nber	hoice Rd.			10f. Zip Code 20886			10g. Citizen		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.	ğ	11. Marital Status 1X Never Marr 3 □ Widowed	ied 2 ☐ Married	12. Was Decedent Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates.			Was Decedent of H	dispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.) 14. Race - Black, \ Specify. A1			can
hour natur dical	olete	/Sne	15. Decedent's cify only highest g	Education			dent's Usual Occup		ing	16b. Kind	of Business I	rican ndustry
within 72 giene. er than " the Med	Completed	Elementary/Sec		College (1-4 or 9	5+)		kind of work dorie O NOT use retired)	during most of work	ang	 Healt	hcare	
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d 2 should alth and I strains		19a. Informant's Na Pauline					-	and Number or Rur s Choice				
ge 1 and nt of Hez :: If item or othe			Cremation 3	Removal from State		Place of Dispo	sition (Name of	:	Date	20c. Locat	ion - City or 1	Town, State
nit. Pa artme ortani injury		4 ☐ Donation 21. Signature of Full	5 Other (Spec		T							
Physician/		23a. Part 1. Enter t	he disease, or cor rt failure. List only Final	pplications that caused one cause on each line	d the deat e.	1251 B th. Do not ent	er the mode of dyir	es of Facility Crematic Heckroti ng, such as cardiac	te, P.A.	Clar	.O. BO	X /84 e, MD 21029 Approximate Interval Between Onset and Death
Medical Examiner		resulting in death)	ſ	Due to (or as	a conseq	uence of):	XCIIII A					
nted d ansit	Examiner	Sequentially list co if any, leading to im cause. Enter Under Cause (Disease or that initiated events	nmediate rlying iinjury	b. Due to (or as	a conseq	uence of):						
iath certificate be executed attending physician and for use as the burial-transit												
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending physicial completed filled in by the funeral director, page 2 should be detached for use as the but	Physician/Medic	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	23c. If yes, outcome 1 Live Birth 4 Pregnant a	2 Feta	aldeath 3	Ectopic pregnan Other (specify)	су		23d	. Date of deli	very Day Year
ss that thighed by be detail		-		contributing to death b		sulting in the u	underlying cause gi	ven in Part I.				the cause of death?
equire	eted			orenej vri	<u></u>							obably 4 🖾 Unknown
The law I ate has b page 2 s	Completed by						-		24a. Was autor perfo 1 \square Yes	osy ormed?	prior to co death?	opsy findings available ompletion of cause of
cian: ertifica ector, I	Be (25. Was case referre	ed to medical	11				lace of Death (Chec				
Physia this o	욘	1 Yes 2 2 27. Manner of Death		Hospital: 1 Inpati 28a. Date of inju		ER/Outpatie	nt 3 DOA Oth	4 ☐ Nursing H				hospice
tending leath. or: After the funer	Certificate:	1 Accident 3 Suicide	5 Pending Investigation 6 Could not	(Month, Da	y, Year)	injury	M 1		28d. Describe h	iow injury oc	curred	
ital or At irs after o al Direct led in by		4 Homicide	determined				eet, factory, office		28f. Location (S City or Tow		ımber or Rur	al Route Number,
he Hospi iin 24 hou he Funer ipleted fil	Medical	(Check 2	Medical Exam	ysician: To the best of niner: On the basis of e rse Practioner: To the	xaminatio	n and/or inves	tigation, in my opini	on, death occurred a	it the time, date a	ind place, and	due to the ca	ause(s) and manner stated.
To t with To t		29b. Signature and	title of certifier				29c. Licens D3714				gned (Month, 25 ,	-
7. √			ess of person who	completed cause of d				···11- ·~	20055			
Stat Registra		31. Date filed (Month	h, Day, Year)	32. Registra		ture	ha Vel	<u>vitte' W</u>	20855			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Perset G923 and 30 62012 arthrell of Health and Mental Hygiene For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year SCHUYLER 2012 Medical 4b. City, Town, or Location of Death **Examiner** 4c. County of Death BALTIMORE N/A 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Director 1 🗓 M 2 🗆 F 73 May 3, 1938 Maryland 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f N/A Baltimore Maryland 1 X Yes 2 No 10e. Street and Number ms 23a or must be r 10f. Zip Code 10g. Citizen of What Country? by Funeral 1615 Popland St., 21226 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Armed Forces?

1 X Yes 2 No Black, White, etc ō 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. Viet Nam 1 Yes 2 X No Specify "natural" Completed 3 Widowed 4 Divorced Specify White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed, (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Crane Operator & Foreman US Government 12 injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Mildred Shriver and Mental F 2 James Schuyler permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print)
Theresa A. Schuyler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Wife) 1615 Popland St., Baltimore, Maryland 21226 20b. Place of Disposition (Name of cemetery, crematory or other place)
Bayview Crematory, Inc. 20a. Method of Disposition 20c. Location - City or Town, State 1 \square Burial 2 X Cremation 3 \square Removal from State 1/25/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Fineral Service Licensee Kevin E Ecker 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 237 E. Patapsco Avenue, Baltimore, Maryland 21225-1856 MO0175 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ preumova, UTI disease or condition weeks Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner burial-transi resulting in death) Last physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 the use as attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Yes 2 No 1 ☐ Yes 2 ☐ Unknown Unknown P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy 1 ☐ Yes 2 ☑ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Tes 24 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at within 24 hours after death.

To the Funeral Director: After tompletely filled in by the funer 28d. Describe how injury occurred 1 Natural work? 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 1.23.2012

Registrar

DHMH 17 Rev 06-2011

State

Suwh

3001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				partment of Health and Nertificate of Death		ene 1. No. 2012 01986
			Decedent's Name (First, Middle, Last)		2 Date of Dooth	3. Time of Death
	Physicia		ABDUL SALAM SAVAGE		Month	Day Year 8:10 P M
Mary.	Medic Examir		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	- Child	4c. County of Death
1			PRINCE GEORGE'S HOSPITAL	CHEVERLY		PRINCE GEORGE'S
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)		8. Date of Birth	9. Birthplace (State or Foreign
	Director		077-90-3283 1 M 2 □ F 73 Yrs.	Months Days Hours Min.	AUGUST ^{ay} 2	lar) 1938 STERRA-LEONE
	- A	١.				
	yland f sho	횼	10a. State 10b. County 10c. City, Town or MD PRINCE GEORGE'S LAI	ocation HAM		10d. Inside City Limits
	Mar 28a- otifi	ie		HAT		1 X Yes 2 □ No
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: I flem Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	10e. Street and Number 6622 WHITFIELD CHAPEL ROAD #304	10f. Zip Code 20706	10g	g. Citizen of What Country? USA
	ems r mu	ڃ	11. Marital Status 12. Was Decedent Ever in U.S. 13	. Was Decedent of Hispanic Origin? (Spe	ecify Yes or No-	14. Race - American Indian,
ဖ	er de or it mine		Armed Forces? 1 □ Never Married 2 ☒ Married 1 □ Yes 2 ☒ No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.
03	rsaft Iral", Exa	g	3 Widowed 4 Divorced If Yes, Give Year or Dates.	1 ☐ Yes 2 X No Specify:		Specify: BLACK
2-0	hou natu dical	Completed by		edent's Usual Occupation	, 16	Sb. Kind of Business Industry
21	in 72 e. nan "	Ę		e kind of work done during most of work DO NOT use retired)	ing	
2	with gien sertt			FESSOR		PRIVATE
pu	filed d oth event	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, Maid	den Surname)
Baltimore, Maryland 21215-0036	should be h and Ment 7 is market fraumatic e	욘	SULAIMAN SAVAGE	ISATU	SAVAGE	
lar	shou and is m			ling Address (Street and Number or Rura		
2	nd 2 s ealth m 27 ner tra			QUARRY DRIVE KILI	LEEN, TEXAS	5 76543
ore	of H		20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Discemetery, cr	osition (Name of ematory or other place)	Date 20	c. Location - City or Town, State
Ē,	Page 1 ment of ant: If it ury or o		4 Donation 5 Other (Specify) MD NATIO		/2012 LAI	UREL, MARYLAND
alt	permit. Departn Importa any inju		21. Signature of Funeral Service Licensee	22 . Name and Address of Facility $ J_{ullet}$	B. JENKIN	NS FUNERAL HOME, INC.
ш	20 5 % 5		I SWREETE !	474 LANDOVER ROAD	HYATTSVII	LLE, MARYLAND 20785
			23a. Part 1. En'er the disear - or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.		or respiratory arrest,	Approximate Interval Between
	nysician/	2 9	Immediate (a se (Final disease or certificition a. A televices):	heft lung		Onset and Death
	Medical					
	Examiner		Sequentially list conditions I h Pulmonary Br	nbolus		
	- +	Examiner	Sequentially list conditions, if any, reading to financiate cause. Enter Underlying			
4	nd	kam	that initiated events			
	ian a	E E	resulting in death) Last Due to (or as a consequence of):			
09	hysician and the burial-transit	dical	d			
87	attending ph	Physician/Me	IF FEMALE:			
9 X	tend ruse	ian/		Ectopic pregnancy		23d. Date of delivery
Box 687	by the at tached fo	/sic	1 Yes 2 No 4 Pregnant at time of death 5 9 Unknown 9 Unknown	Other (specify)		Month Day Year
P.O.	d by 1	Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Port I	OOs Did tobas	co use contribute to the cause of death?
T 4	signed to	by	Tarin out of Signature of the fact of the	and onlying dadde given in rate.		2 No 3 Probably 4 🔀 Unknown
rds	been si	stec			1 L Yes	2 No 3 Probably 4 Unknown
Records,	has b	Completed			24a, Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
a a	cate ha	S			performed	
tal	certificate rector, pag	Be	25. Was case referred to medical examiner?	26. Place of Death (Check	k only one)	
<u> </u>	this o	은	1 ☐ Yes 2 🛣 No Hospital: 1 🂢 Inpatient 2 ☐ ER/Outpati		me 5 🗆 Residenç	e 6 D Other (Specify)
סו	th. After this certifics funeral director, p	ate	27. Manner of Death 1 🛣 Natural 5 🗌 Pending (Month, Day, Year) 28b. Time injury	work?	28d. Describe how i	njury occurred
io i	death. :tor: A / the fu	iţic	2 Accident Investigation 3 Suicide 6 Could not be	M 1 ☐ Yes 2 ☐ No		
Division of Vital Records, P.O. Box 68760	s after death	Certificate:	4 Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, tate)
	ours a		Occ Coation 1 No Coation Physician Talk had a land a land			
H	e Funeral Direct	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or inve	stigation, in my opinion, death occurred at	the time, date and p	lace, and due to the cause(s) and manner stated.
the c	within 24 hours and the To the Funeral Direction of the Completed filled in the Complete filled fi	Σ	only one) 3 ☐ Certifying Nurse Practioner : To the best of my knowledge 29b. Signature and title of certifier	death occurred at the time, date and place 29c. License number		use(s) and manner as stated. Date signed (Month, Day, Year)
-	SF0		Karen Brooks		230.	1/33/13
			30. Name and address of person who completed cause of death (Item 23a) (Type,	1047183		1
			1/ PACI Ilia	al DR Chever	0/11 0	no 26785
	Stat	e_	31. Date filed (Month, Day, Year) 32. Registrar's Signature	LI DI CHEVER	7/1	10 00100
	Registra		JAN 2 7 2012 Janua B. A	arked		

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. end #26 Per PHY G923 1/27/2012 JH State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 17 201^{Year} 12:15 PM Kathryn Dolores Seebacher January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Parkville Morningside House If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Dav. Year 212-26-2032 1 □ M 2 🗓 F **Director** 83/rs. 1928 Maryland 11, Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location with the Maryland 10a. State 10b. County items 23a or 28a-f sho ner must be notified at **Funeral Director** 1 🗌 Yes 2 ី No Rosedale Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21237 9551 Devonwood Court permit. Page 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Marian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No þ 1 Never Married 2 😾 Married 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Her own home Homemaker 8th Grade Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Annabelle Phillips John Jacob Wiessner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21237 Baltimore, MD William L. Seebacher - Husband 9551 Devonwood Ct. 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 St Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Joseph Church Cem: 1/20/2012 Baltimore, Maryland 22. Name and Address of Facility Schimunek Funeral Home, Inc. Signature of Funera Service Licenses 9705 Belair Road Baltimore, MD June Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest thock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ phosytic runic disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Li Fetal usea
Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Dav signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Hyper lipidemia 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? 2 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: XX Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDDA After this 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No funeral 27 Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending after death. Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Medical LECertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 I Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 55346 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tason Goodman 7602 Bel Air Road Baltimore MD Goodman 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Smith Joan January 2-012 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore City Johns Hopkins Bayview Medical Center Baltimore If Under 1 Year
Months Days 8. Date of Birth 11/17/1930 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday, If Under 24 Hrs. Hours Min. **Funeral** 1 □ M 2 F Mary land 217-26-9260 81 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 ☐ No Director Baltimore City Baltimore, Maryland 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? USA 7157 Gough Street 21224 Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No \$ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 10th Customer Service Representative Label Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Reichert Frances Kaplan မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George K. Smith 5839 Daybreak Terr., Baltimore, MD 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/24/2012 Baltimore, MD Dak Lawn Cemetery 22. Name and Address of Facility Charles S. Zeiler, Inc., 21. Signature of Funeral/Service Licensee 6224 Eastern Ave, Baltimore, MD 21224 Part). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Chronic Ob structive

Due to (or as a consequence of): Pulmonary **Physician** /Medical Examiner Sequentially list conditions, it is a cause. Enter Underlying Cause (Disease or injury that initiated events Examine Dire to (or as a consequence of) Attending Physician: The law requires that the death certificate be executed burial-trar and resulting in death) Last Due to (or as a consequence of) Box 68760, attending physician Physician/Medical as ase a 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 - Ectopic pregnancy for in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 2 No P.O. 9 Unknown ģ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 certificate has 2 No 2 □ No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient examiner? Other: 4 \square Nursing Home 1 Yes 2 No ၉ 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 4 hours after death.

-uneral Director: After the lilled in by the funera Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined ō completely filled in the Hospital 24 hours Funeral 29a. Certifier 1 🖪 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29c. License number

State Registrar SARAH RAMSAY MD

31. Date filed (Month, Day, Year)

JAN 2 7 2012

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4940 Eastern Avenue, Baltimore, MD, 21224

ORIGINAL

RE5-000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 20 | 2 1990 1 - State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 Patrice Viola Saxton January 7:12 a M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Harford Bel Air Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. Hours **Director** 068-32-5168 1 🗌 M 2 🔀 F 89 Usual Residence of Deceder Sep. 27, 1922 New York show 10a. State death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 X Yes 2 ☐ No New York New York New York ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? rms 23a or must be r Funeral 345 West 145th St. 10031 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. permit. Page 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hyglene.

Department of Health and Mental Hyglene.

The marked other than "natural", or ite month in the medical Examiner any injury or other traumatic event, the Medical Examiner. Black, White, etc. ģ 1X Never Married 2 ☐ Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Completed 3 Widowed 4 Divorced Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Public Schools 5+ Kindergarten Teacher Be 17. Father's Name (First, Middle; Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Oliver Wendall Saxton Earle Dunlap Day 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marjorie P. Clarke / Niece 528 East Broadway, Bel Air, MD 21014 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 1-24-12 Towson, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Pira disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine for use as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician d be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 45 1 🗌 Yes Completed peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director; After this certificate has completely filled in by the funeral director, page 2 autopsy performed 2 No 1 ☐ Yes 2,🗹 1 🗌 Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1260768 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MUHAMMAD TOKHADAR, 500 UPPER EHESAPEAKE Dr., BELPIR JOIL OV 31. Date filed (Month, Day, Year) State JAN 27 Registrar

Sax

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. 1tem 26 per phys g923 1-27-12 vt
State of Maryland / Department of Health and Mental Hygiene 1 - For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 Frederick Joseph Schmoll 3:55 P M January Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 22 East Gordon Street Harford Bel Air Social Security Number 7. Age (In vrs. last birthdav) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Days Hours **Director** 212-40-8225 1 🔀 M 2 🗆 F Maryland 69 Feb. 17, 1942 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director 1 Tes 2 No Bel Air Maryland | Harford 10g. Citizen of What Country? 10e. Street and Number ō 10f. Zip Code ems 23a or 1925 Cypress Drive Funeral 21015 items 2 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, permit. Page 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medicial Examiner. Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: 3 Divorced 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working Department of the life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Federal Agent Treasurv Δ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ Leo Edward Schmoll Stella Frances Skoviak TANUACY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1925 Cypress Drive, Bel Air, Maryland 21015 Judith K. Schmoll / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp 1-27-2012 Towson, Maryland 22. Name and Address of Facility McComas Funeral Home, 50 W. Broadway, Bel Air, Maryland 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final EREBROV Onset and Death Physiciso/ disease or condition Medical resulting in death) as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last use as the burial-tran Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death sate has been signed by the a page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an To the Hospital or Attending Physician: The law r within 24 hours after death. To the Funeral Director: After this certificate has b autopsy perform 1 🗌 Yes completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2nd Hospital: Other: 2 No 1 Yes ဂ္ 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA ome 5 Knesidence 6 Nother (Specify) 28d. Describe how injury occurred residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) f death (Item 23a) (Type, Print 30. Name and ado 21093 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 100 Medical Facility Name (if not institution, give street and number **Examiner** 4c. County of Death tospeci 0 Stown alt Birthplace (State or Foreign Country) Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, **Funeral** Min 246-30-8168 **Director** 1 M 2 🗆 F Usual Residence of Decedent 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland must be notified at 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director 1 Xes 2 No 9 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc o, þ 1 Never Married 2 Married 1 Yes
If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 Divorced "natural" Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) than Elementary/Şecondary (0-12) College (1-4 or 5+) the XXrrou and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address Department of Health a Important: If item 27 is any injury or other tra 20a. Method of Disposition 20b. Place of Disposition (Name of Date l 🖾 Burial 2 🗌 Cremation 3 🔲 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) 2012 Funeral Service 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ mor Medical Due to (or as a consequence of): Examiner Sequentially list conditions, in any, reading to infinite cause. Enter Underlying Examiner Due to for selection resquence of, as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physiciar Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? for Day Month Year be detached the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Probably Completed plnous 24b. Were autopsy findings available prior to completion of cause of has page 2 autopsy performed? death? certificate Yes 1 Yes the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Moth this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of s after death.

I Director: After the Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 For State Registrar Certificate of Death Reg. No. 3. Time of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2:58 mi Medical 4a. Facility Name (if not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death **Examiner** 7 more emori 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours (Yrs. **Director** 28a-f show 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State Director 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 100 Blac If Yes, Give Year or Dates "natural", 3 Nidowed 4 Divorced traumatic event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Machine marked other Be 17. Father's Name (First, Middle, Last) ပ္ should and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street permit. Page 1 and 2 sl Department of Health a Important: If item 27 is TIMERE other 20b. Place of Disposition (Name of 20c. Location -20a. Method of Disposition Surial 2 Cremation 3 Remo injury or 5 Other (Specify 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiad or respiratory a Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Anoxic Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death be detached for use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed After this certificate has 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No 1 Nnpatient 2 ER/Outpatient 3 DOA မ . Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 Yes 2 No 24 hours after death. Funeral Director: At Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) MO AT 2438946 D16 2012 who completed cause of death (Item 23a) (Type, Print) · Univ. Privy Baltimore MD 21218 It tamb alam 201 E Charmian

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Smith 2012 January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore HOPKINS Hospital Johns Birthplace (State or Foreign Country) **Funeral** 216-62-4806 **Director** 56 ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10c. City, Town or Location death with the Maryland 10a. State Director 1 Yes 2 No 10e Street and Number 10g. Citizen of What Country? Funeral items 2 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. 0 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify "natural". Completed 3 Widowed 4 Divorced Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) AND Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Secondary (0-12) College (1-4 or the Be 18 Mother's Name (First, Middle, Maiden Surname 17. Fathe 's Name (First, Middle, Last) Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Nu 10Th A Page 1 and 2 20b. Place of Disposition (Name of 20a. Method of Disposition Date permit. Page 1 a cometery, crematory or other 1 Burial 2 ☐ Cremation 3 ☐ Removal from State injury (4 ☐ Donation 5 ☐ Other (Specify) 21. Sign Jure of For eral Service Licens 6 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ oronary disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence on The law requires that the death certificate be executed as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last nding physiciar Physician/Medical Box 68760 IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month for Day Pregnant at time of death 4 ☐ Pregnant : g ☐ Unknown been signed by the a g Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? cate has to page 2 s autopsy performed 2 🗆 No 1 Yes certificate Yes 2 Division of Vital 25. Was case referred to medica 26. Place of Death (Check only one) or Attending Physician: director Be 1 Tyes 2 No 1 Nanpatient 2 ER/Outpatient 3 DOA ၉ 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: iniury Natural 5 Pending 1 Yes 2 🗌 No Accident Suicide Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated pertifying Nurse Precitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and t completed cause of death (Item 23a) (Type, Print) 30. Name and address of pe XIV Street Baltimore, mo unia 31. Date filed (Month, Day, 32. Registra signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Robert Morris Sellers Sr. 011/19/2012 12:05 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Atlantic Gerneral Hospital Berlin Worcester 5. Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Birthplace Country) MD Days 1 X M 2 □ F Min. 219-26-2844 Hours Director (Month, Pay, Year) 938 Usual Residence of Decedent show 10a. State notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 28a-f MD Worcester Berlin 1 Yes 2 No ö 10e Street and Number 10f. Zip Code permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be I 10g. Citizen of What Country? Funeral 36 Lookout Point 21811 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 X Married Y☐ Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Completed 3 Widowed 4 Divorced Year or Dates. 1960 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Quality Control Superv Automotive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ralph Patrick Sellers Christine Elaine Sellers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Sellers Wife Lookout Point Berlin MD 21811 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 Donation 5 Other (Specify) Atlantic Crem 1/24/12 Glen Burnie MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Simplicity Crem & Fun Serv ThomasAllenPA 7090 Ridge Rd Hanover MD 23a. Part 1. Enter the disease, or complications that caused the deat / Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause or elect line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sici_n disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of). burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Month 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Uniknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has performed? Yes 2 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certifica completed filled in by the funeral director, I of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 40 Hospital Other: မ 1 Dinpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred ☐ Watural 5 Pending injury Division Accident
Suicide 1 Yes 2 No Investigation Sellers, 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Swampiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nu/se Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title 29d. Date signed (Month; Day, Year) of death (Item 23a) (Type, Print) 31. Date filed (Month. De State

DHMH 17 Rev 7/2009

Registrar

01/19/2013

080

DOB 03/11/1938

Robert

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene										01000					
			Registrar 1. Decedent's Name (First, Middle							Reg. No. 2 3. Time of Death					
Physician/ Medical			Mary Shimunek						January	25, 20	5:10 a M				
Examine			4a. Facility Name (if not institution, give street and number) 204 West Monument Street					Location of Death		4c. County of Death n/a					
Fur	Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)					ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	. Date of Birth 9. Birthplace (Stat					
	ctor		230-40-3704 Usual Residence of Decedent	1 🗆 M 2 🔀 F	7	6 Yrs.	Months Days	Hours Min.	Nov 26,		Count Hawa				
land	dat	tor	10a. State 10b. County		10c. City	y, Town or Loc	ation				10	0d. Inside City Limits			
Mary - 28a-1	notifie	irec	MD n/a			Baltim			1			1x Yes 2 □ No			
vith the	st be	Funeral Director	204 West Monument Street				10f. Zip Code 212(01	10	g. Citizen of WI U.S		try?			
death v	items ner mu		11. Marital Status		lent Ever in U.S		Vas Decedent of His Yes, specify Cubar	spanic Origin? (Sp		14. Race	- America				
336 affer al", or	xamir	d by	1 ☐ Never Married 2 ☐ Marr 3 👿 Widowed 4 ☐ Divorced	ied 1 X Yes If Yes, Give Year or Dat	2 No	1	☐ Yes 21 No		, ,	Specify:	Whi				
5-0(! hours "natur	dical	plete	15. Deceden	it's Education st grade completed)	.65.		ent's Usual Occupa		ding 1	6b. Kind of Bus	siness/Inc	lustry			
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filed w	vent, t		17. Father's Name (First, Middle, L	ast)				18. Mother's Nam	ne (First, Middle, Ma	iden Surname)					
ylar Jid be I Mente	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.				oebler			Gloria	Jean		oss				
Mal 12 sho lith and 27 is r	r traun		19a. Informant's Name/Relationsh Onahlea Shimune		ter	1			al Route Number, C Baltimore		ate, Zip C 11201				
Baltimore, Maryland 21215-0036 Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Minodant: If item 27 is marked other than "natural", o	r Cthe		20a. Method of Disposition 1 □ Burial 2 🛣 Cremation		20b. P	lace of Disposemetery, crem	sition (Name of latory or other place	e) :	I .	oc. Location - 0	City or To	wn, State			
Itim it. Pag rtment rtant:	njury o		4 Donation 5 Other (S	pecify)	Hil		erv Corp	1/27		Towson,					
Bal perm Depa	any i		21. Signature of Funera Pervice L	Censee Willia	am G. D	au 22.	Name and Addres		uck Towso Towson, M			lome, Inc.			
		-	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between												
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Box death o	d for use as th	Physician/Me	and the past 12 months? 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 1 ☐ Yes 2 ☑ No 1 ☐ Live Birth 2 ☐ Fetal death 5 ☐ Other (specify)							Mont	ate of delivery Ionth Day Year				
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ords, P.O. Borned in the destruction been signed by the state of the s	ld be d	ا ۾	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.									ably 4 Unknown			
Records, The law requires ate has been sig	2 shou	Completed	4						24a. Was an autopsy	24b. W	ere autop	sy findings available inpletion of cause of			
//tal Reco sician: The law / certificate has b	; page								performe 1 Yes 2	d?/ de	eath?				
/ital sician certifi	director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	npatient 2 🗌	EB/Outnotion	Othe	r:	k only one) ome 5 Residence	on C C Other	(C===if.)				
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Sion ttendii death. stor: Af	y the fu	Certificate:	2 Accident Investig	not be	of Injury - At hor	me farm stre		Yes 2 □ No	28f Location (Stro	at and Number	or Pural	Poute Number			
Division of Vital tal or Attending Physician s after death. al Director: After this certifi	filled in by the	Ser	4 Homicide determined 286. Place of Injury - At nome, farm, street, factory, office building, etc. (Specify)							on (Street and Number or Rural Route Number, r Town, State)					
	within z4 hours affer To the Funeral Direc completely filled in by	Medical	29a. Certifier (Check (Check 20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
To the Vithin 2		ž	only one) 3 L Certifying 29b. Signature and title of certifier	Nurse Practitioner:	To the best of m	iy knowledge,	29c. License	number	290	I. Date signed (
Chelle DS								5076	1760 1/26/2012.						
<u> </u>	`		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chreles Veng - 1407 York Rd. Ste 307, Lutherville, Mcl 21093												
D.	State	e	31. Date filed (Month, Day, Year) JAN 2 7 20	32. Re	gistrar's Signat	ure Jacks			1	1-/		· ·			
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	ъ	,	Decedent's Name (First, Middle, Li	ast)					2. Date o	f Death		Voor	3. Time of Death		
	Physicia Medio	al	Fred Thomas Tea					January			1^{1} , 2012^{r} 12:20p M				
	Examir	er	4a. Facility Name (if not institution, give					4b. City, Town, or Location of Death Sandy Spring				4c. County of Death Montgomery			
property.	Funeral		Friends Nursing 5. Social Security Number 6.	<u> </u>	je (În yrs. la	st birthday)	If Under 1 Year	If Under 24		Birth		g. Birth	place (State or Foreign		
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	show dat	١	Usual Residence of Decedent 10a, State 10b, County		10c. City	, Town or Lo	cation			-			10d. Inside City Limits		
	arylar 8a-fsl ified	ecto											1 💢 Yes 2 □ No		
	the N or 28	ä	10e. Street and Number			-51						What Cou	ntry?		
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	r deat r iten iner n		11. Marital Status1 Never Married 2 Married	12. Was Decedent Armed Forces?		5. 13. \ I	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? n, Mexican, Po	? (Specify Yes or uerto Rican, etc.)	No-		ce - Ameri ck, White,	can Indian, etc.		
036	rs after deat ral", or iten Examiner	q pe	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give 1 Year or Dates.			-			″Whit	ite					
Maryland 21215-0036	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho ledical Examiner must be notified at	Completed by	15. Decedent's (Specify only highest of			(Give	dent's Usual Occupa	ation Juring most of	workina	16b	•	Business In			
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Baltimore,			21. Signature of Funeral Service Lice		C	hurch 22	Cemetery Name and Addres	ss of Facility	leck Fu	neral	Hom	e	NO		
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89		Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			Ectopic pregnanc	ev.			23d. D	ate of deliv	,		
Box	death of he atter	sici	in the past 12 mont s? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant 9 Unknown			Other (specify)				М	onth	Day Year		
P.O.	at the d by tl letach	, Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							Did tobacc	co use contribute to the cause of death?				
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ord	w requ	plete	Aspiration	Ų.			Was an autopsy								
Rec	The law ate has page 2:	Som								performed Yes 2		death?			
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	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate his completed filled in by the funeral director, page	Medical	(Check 2 Medical Exa	miner: On the basis of urse Practioner: To the	examination	and/or inves	tigation, in my opinio	on, death occur	rred at the time, d	ate and pla	ace, and di	ue to the ca	ause(s) and manner stated		
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			Jelesoen 1	K Magri	M	Ò	Doc	6983	29	1-	-26	-12			
-			30. Name and address of person who		death (Item	- 4	Print)	lis bur	CIA M	12	180	2			
	Sta	ie.	31. Date filed (Month, Day, Year)	3. Registi	rar's Signat	x 261	0, 000	13 001	7, 141	UU		-			
	Registr		31. Date filed (Month, Day, Year) 2	UIZ Ceren	NA	1. ADA	West of the second								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 1505 PM Physician/ Z O/Z Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** OWSON 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Sex 1 ★ M 2 □ F **Funeral** Days Hours Min. VA 10/1107 230-22-8325 **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location or than "natural", or items 23a or 28a-f shorthe Medical Examiner must be notified at Director MD N/A Baltimore 1 🗆 Yes 2 🏝 No 10f. Zip Code 21213 10e. Street and Nur 1700 N. 10g. Citizen of What Country? Gay St. - Apt. 208 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian, 11. Marital Status African ş 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: If Yes, Give Year or Dates Specify Amer Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 72 | th and Mental Hygiene. 7 is marked other than "r Self Elementary/Seconday (0-12) College (1-4 or 5+) Roofing traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Helen Harrison ပ James Taylor 19a. Informant's Name/Relationship (Type, Print)
Lucy A. Taylor/Wifw 19b. Mailing Address (Street and Number or Rural Route Number, City or Jown, State, Zip Code) 1700 N. Gay St. -Apt. 208, Balt., MD 21213 1 and 2 s of Health item 27 20a. Method of Disposition 20b. Place of Disposition (Name of 2/3/12 20c. Location - City or Town, State Mt. Carmel XCem. 1 XBurial 2 Cremation 3 Removal from State 0 Balt.,MD Department Important: If any injury or once. 4 Donation 5 Dother (Specify) 22, Name and Address of Facili Mari P. Close F. Svs. PA 5126 Belair Rd, Balt., MD 21206-5105 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Cardiomyon Onset and Death Schemic Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Dav Year 2 No tor: After this certificate has been signed by the the the funeral director, page 2 should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performe death? 2 No 1 🗌 Yes Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence မ 1 Yes 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at e Hospital or Attending Pl n 24 hours after death. e Funeral Director: After tl Certificate: 28d. Describe how injury occurred injury work 1 Natural 5 Pending 1 Yes 2 🗆 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide completed filled in by determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signatu e and title of certifie 29d. Date signed (Month, Day, Year) 26 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar AARON

31. Date filed (Month, Day, Year)

Phonles

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1- For State Certificate of Death	01999								
Physician/ Medical Examiner	Vonnotto D. Thomas	me of Death 119 hrs								
	4a. Facility Name (if not institution, give street and number) Johns Hopkins Hospital 4b. City, Town, or Location of Death N / A									
Funeral Director	5. Social Security Number 2 1 4 - 9 4 - 1 7 0 4 6. Sex 1 Months Days Hours Min. 2 1 0 / 6 6 Foreign 1 Country) 9. Birthplace Foreign 1 Country)									
te Maryland or 28a-f show any fied at once, Director	MD N/A Baltimore	Inside City Limits Yes 2 No								
er death with the or items 23s r must be noti	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American In White, etc. African 2 Widoward If Yes Give Yest 1 Ves Cive Yest 1 Ves Cive Yest 1 Ves Cive Yest	dian, Black,								
215-0036 be filed within 72 hours after the within 72 hours after the within the Medical Examine out, the Medical Examine Be Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	у								
MD 21215-0036 d 2 should be filed within 7 th and Mental Hygiene. n 77 is marked other than numatic event, the Medica To Be Compile										
MD 21 d 2 should it th and Mer a 27 is man unmaric ev	19a. Informant's Name/Relationship (Type, Print) Sharon A. Gilliard/Mother 1247 E. Northern Pkwy, Balt., MD 2125									
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed withit Department of Health and Mental Hygiene. Important: If item 27 is marked other to injury or other traumatic event, the Med	20a. Method of Disposition 1 Name of cemetery, 1 Name of Cemetery, 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, 20c. Loc									
Balt permit. Depart Impor injury	21. Signature of Fune al Servic Licensee 22. Name and Address of FacilityHari P. Close F.Svs, I 5126 Belair Rd, Balt., MD 21206-510									
Physician /Medical Examiner	failure. List only one cause on each line. Immediate Cause (Final disease a. Methadone Intoxication and Cocaine Use	proximate Interval etween Onset and Death								
	or condition resulting in death) Due to (or as a consequence of): b. if any, leading to immediate Due to (or as a consequence of):									
ted 1 Insit Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of):									
50, te be executed ysician and burial - transit	d. ☐ AMENDED 23a,pt.II,27,28a-f,per me,g923 1-31-12 sm									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	Year								
s, P.O. E uires that the or a signed by the detached be detached ed by Ph	Harmontongine Cardiovascular Disease Probable Pneumonia 1 Yes 2 No 3 Probably	4 Unknown								
Division of Vital Records, P.O. Division of Vital Records, P.O. Lai or Attending Physician: The law requires that the rs after death. a) Director: After this certificate has been signed by all birector; page 2 should be detactly led in by the funeral director, page 2 should be detactly ertification: To Be Completed by P	24a. Was all autopsy autopsy performed? 1 ✓ Yes 2 \(\text{Non No 1} \) No 1 ✓ Yes	etion of cause of								
f Vital Physician: or this certif ral director, To Be	25. Was case referred to medical examiner? 1 V Yes 2 No No No No No No No									
Division of N Division of N To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral ledical Certification: T	27. Manner of Death 1 Natural 5 Pending 2 X Accident 1 Natural 5 Pending Investigation 1 Yes 2 No 28d. Describe how injury occurred subject took drugs									
Division or spital or Attending, hours after death, cfilled in by the fune Certification:	Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 203 Douglas Baltimore, MD.	28f. Location (Street and Number or Rural Route Number, City or Town, State) 203 Douglas Ct. Baltimore, MD.								
To the Hospital within 24 hours To the Funeral completely filled	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s) and manner as stated.									
• • • • • • • • • • • • • • • • • • •	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, D January 24, 2012	lay, Year)								
March	30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223									
State	31. Date filed (Month, Day, Year) 82. Registrar's Signature									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 25° 2012 8:30 A M Raymond Edward Testerman January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Jarrettsville 1350 Knopp Road Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, May 17, 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Country) Missouri 1 XM 2 🗆 F 1947 Director 217-54-9627 64 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits death with the Maryland Director 1 Yes 2 No Maryland Harford Jarrettsville 10e. Street and Number 10g. Citizen of What Country? Funeral 1350 Knopp Road 21084 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian 1 Never Married 2 Married þ 1 Yes 2 X No Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 X No Specify: Specify: White "natural", 3 Widowed 4 Divorced Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry should be filed within 72 h h and Mental Hygiene. 7 is marked other than "r (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+ 12 Assembly Line Worker Rubber Manufacturer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Rov Carl Testerman Department of Health and Meni Important: If item 27 is marke any injury or other traumatic Eva Jane Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 i Eula Quick / Sister 1350 Knopp Road, Jarrettsville, Maryland 21084 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Page ment or 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Gdn: 1/28/2012 Bel Air, Maryland f Fun ara Service Liv 22. Name and Address of Facility McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, Maryland 21014 23a. Part 1. Enter the disease, or como shock, or heart failure. List only on tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. Approximate Interval Retween Immediate Cause (Final Onset and Death Covsician/ liver canno disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Due to (or as a consequence of): Exami Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death 2 No the 9 Unknown Unknown Records, P.O. þ signed k 1 be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ncate has been sig r, page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has performed? Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 🗌 Yes 24 hours after death.

Funeral Director: After this of leted filled in by the funeral dir ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work? 1 ☐ Yes 2 Accident
3 Suicide
4 Homicide 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 1 Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

State Registrar

DHMH 17 Rev 7/2009

29b. Signature and title of certifier

Day 2

31. Date filed (Month,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

34208

Wornisville Rd, Jagre Houth

29d. Date signed (Month, Pay, Year)

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